Government of the District of Columbia
Anthony A. Williams, Mayor

First Citywide Comprehensive Substance Abuse Strategy for the District of Columbia

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Presented By The
Mayor's Interagency Task Force
On Substance Abuse Prevention, Treatment & Control

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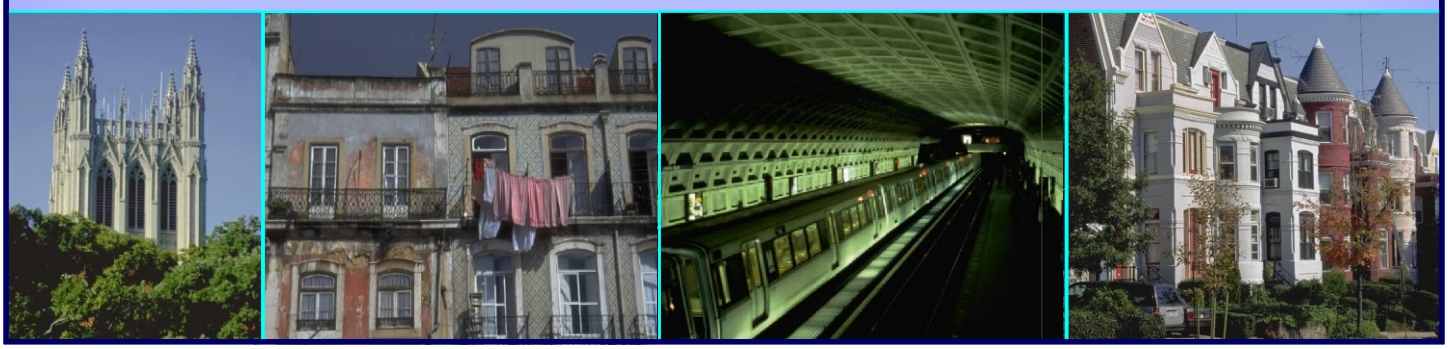

The Mayor's Interagency Task Force on Substance Abuse Prevention, Treatment and Control

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Chapter 1

INTRODUCTION

A SUBSTANCE ABUSE STRATEGY FOR THE DISTRICT OF COLUMBIA

The statistics on substance abuse among the residents of the District of Columbia (the District) are disturbing. Approximately 60,000 residents--nearly one in 10--are addicted to illegal drugs or alcohol. Of the 1.3 million emergency room visits in the District, about 40 percent are related to drug and alcohol abuse. Fifty percent of the reported motor vehicle crashes in the District are associated with substance abuse. Nearly 15 percent of new mothers report having used illicit drugs during pregnancy. Eighty-five percent of foster care placements are connected with substance abuse. Twenty-seven percent of the cumulative reported AIDS cases in the District are related to intravenous drug use. And one source estimates that the social costs of drug and alcohol abuse to the District are more than $1.2 billion. Adding tobacco-related social costs raises this figure to more than $1.7 billion.

These troubling statistics, however, must be viewed against a larger background, one that includes the overall positive strides that have been made in recent years by the city. The District of Columbia has achieved real progress in reducing drug-related crime and violence in the past decade and in making neighborhoods safer and more secure. Efforts to restore its fiscal health and economic vitality are attracting new residents and businesses. Not all of the news is good, however, in particular the recent resurgence of homicides in the District.

Much of the District's progress so far is due, in part, to ongoing efforts to prevent, treat, and control substance abuse. The cocaine epidemic that ravaged the city for over two decades and nearly destroyed a generation of the District's youth has subsided. Today, rates of cocaine use by youth are low. Although no one can deny progress, serious hurdles remain, chief among them the need to close the "treatment gap" between the city's drug treatment capacity and the number of individuals requiring help. Equally important is the need to continue a strong substance abuse prevention effort that will enable District youth to make healthy lifestyle choices. If the District is to become the capital city that every American can feel proud of, then recent positive strides against substance abuse must continue.

THE MAYOR'S TASK FORCE

In response to the impact of substance abuse on the District's health, safety, and financial stability, Mayor Anthony A. Williams appointed an executive-level task force to prepare and recommend the citywide

> *"A Substance Abuse Strategy for the District must represent a firm commitment to address both the public safety and public health aspects of the problem."*
> – DC Mayor Anthony A. Williams

Substance Abuse Strategy (Strategy) and budget. In May of 2001, the mayor established the Interagency Task Force on Substance Abuse Prevention, Treatment, and Control (the Task Force) and formally commissioned the group to oversee the District's substance abuse policies and interagency and intergovernmental substance abuse activities. According to the mayor's order, the Task Force is charged with "enhancing the effectiveness of the city's health, social service, and criminal justice system by monitoring use of federal grant funding together with local funding to implement innovative substance abuse programs." Furthermore, the mayor's order requires the

Task Force to "establish well-defined performance outcome measures that will facilitate an assessment of costs and benefits in investments in substance abuse prevention, treatment and control."

A COMPREHENSIVE STRATEGY

For the past year the Task Force has worked closely with the mayor's staff as well as with a wide variety of experts and stakeholders to develop a Substance Abuse Strategy that is both accountable to taxpayers and well coordinated with existing District agency plans and budgets. At a minimum, the Strategy is designed to address two enormous and perhaps ambitious challenges: reducing the city's addicted population by 25,000 and reducing the social costs of substance abuse by $300 million by the year 2010. In addition, the Task Force has also identified policies to address substance abuse among District youth, to close the gap between the numbers of individuals requiring treatment and the services available, and to enhance coordination between city and federal agencies.

> *"The mayor and the Task Force are committed to a strategic plan with the built-in support of a wide community of stakeholders."*-- Metropolitan Police Department Chief Charles H. Ramsey

From the outset, the mayor's approach to developing the Substance Abuse Strategy for the District has represented a firm commitment to address both public safety and public health aspects of substance abuse. Clearly, District residents are entitled to protection from any unlawful behaviors, including those of drug offenders. And drug addicts--as individuals suffering from a chronic, relapsing brain disease--require comprehensive, effective treatment.

The mayor's selection of Task Force leadership reflects his balanced approach to the issue. D.C. Department of Health Director James A. Buford and Metropolitan Police Department Chief Charles H. Ramsey are working in close collaboration with the mayor's staff to ensure a comprehensive line of attack.

THE SCOPE OF THE PROBLEM

Recent data make it clear that the city's substance abuse problem as a whole is far more extensive than previously recognized. In December of 2000, the DC Department of Health engaged Westcom International, Ltd., to conduct the nation's first-ever, comprehensive citywide household survey on substance abuse. The results of the survey of 1,535 District households reveal startling information. For illegal drugs alone, the rate of addiction in DC is nearly 40 percent higher than the rate of addiction for the nation that same year. Nine percent of District residents report a dependence on drugs and alcohol, compared with a national estimate of 4.8 percent identified by the federal government's 2000 National Household Survey on Drug Abuse. Furthermore, the survey's addiction rates are considered to be conservative because, like all household surveys, the DC Household Survey excludes institutionalized and homeless populations. Moreover, one out of six adolescents–children between 12 and 17 years old–reported having consumed alcohol in the month leading up to the survey. Twenty-one percent of adolescent respondents had used an illicit drug in the past year, and 7 percent reported using an illicit drug within the past month.

> *"The Strategy presented here represents our collective will to aggressively target addiction, so our citizens can enjoy healthy and productive lives."* – D.C. Department of Health Director James A. Buford

At the mayor's request, the Task Force conducted an analysis of the District's drug programs and governmental expenditures. Each District agency provided the Task Force with an inventory of substance abuse-related programming and financial figures. The analysis revealed that District agencies spent

more than $289 million of local funds on treatment, prevention, and law enforcement efforts in Fiscal Year 2003. Federal expenditures add another $61 million to overall governmental expenditures in the District. Another $7 million are funds from "other" sources, which include monies the District receives from non-tax revenue. It must be clearly understood, however, that these funds, approximately $356 million, include an extensive array of programming that targets substance abuse secondarily to other issues. In other words, only $53 million, or 15 percent, of the total $356 million expenditure can be tied to programs whose primary focus is substance abuse-related. Furthermore, only $35 million of the $53 million is dedicated solely to the direct provision of substance abuse treatment programs.

The analysis of the District's drug programs and budgets underscores two main points. First, a significant percentage of the budget is already directed to solving the problem of substance abuse and its consequences. Second, this substantial amount may still be inadequate, especially with regard to two critical missions: 1) closing the gap between the number of addicts requiring treatment and the services that are available and 2) strengthening the District's substance abuse prevention programs.

The wisdom of investing in treatment, in particular, becomes especially clear when one takes a longer-term perspective. Effective treatment, meaning treatment that is comprehensive and includes aftercare, returns more in the long run to its community than it initially costs. Recent research has found that every dollar spent on effective treatment leads to a $7.46 reduction in crime-related spending and lost productivity. When savings related to health are included, every $1 invested in addiction treatment programs yields $12 in savings.

More and more politicians, policymakers, and members of the public are supporting increased treatment funding as reasonable "venture capital" whose upfront investment yields downstream benefits. For example, in April 2000, the District of Columbia Council enacted the Choice in Drug Treatment Act of 2000 (the Act) which established a voucher system allowing patients to choose services from an approved list of providers. The Act also contained separate provider certification requirements. Ultimately the Act will enhance access to treatment services by expanding the pool of providers that meet certification requirements. In addition, the Act established the Addiction Recovery Fund as the sole source of payments to participating certified treatment providers. Finally, a portion of the monies allocated to the fund was earmarked to implement a pilot substance abuse treatment program for youth. However, because these funds were previously targeting adults, fewer adults will be served through this funding source.

> *"Upfront investment in effective prevention and treatment will save taxpayer money and the lives of District residents."*
> -- Addiction, Prevention, and Recovery Administration Interim Deputy Director William H. Steward

The certification of treatment providers results in tangible financial benefit to the District of Columbia. Certification is a prerequisite to gain Medicaid reimbursement for treatment services provided to Medicaid eligible clients. With the approval of the Medicaid Rehabilitation Option for Substance Abuse services in 2003, the District will gain access to additional substance abuse treatment dollars.

A COMMUNITY APPROACH

The mayor and the Task Force are committed to the development and implementation of a strategic plan that has the built-in support of a wide community of stakeholders. To foster community buy-in, the Task Force sponsored focus groups that evolved into Strategy Working Groups in the areas of prevention, treatment, and law enforcement. In many instances, individuals

within the same field met for the first time. In addition, the Task Force sponsored a series of Neighborhood Forums to gather the community's perspectives and to incorporate them into the Strategy. The Strategy Working Groups and Neighborhood Forums identified the most pressing issues and provided the Task Force with valuable input on strategic goals, objectives, and activities. In the coming year as the Strategy is implemented, the Working Groups will serve as a major form of linkage to the entire community of District stakeholders.

RESULTS-DRIVEN STRATEGY

The mayor's concept of the Substance Abuse Strategy for the District has always been one that is fully accountable to the city's taxpayers. In an effort to ensure effective monitoring and measurement of Strategy outcomes and results, the Task Force consulted the nation's leading experts on drug policy and budget. The District's approach incorporates the latest and most sophisticated methodology in the field of drug policy, including the "logic model" technique, which utilizes a systems approach and establishes accountability by linking programming, budget, and measurable goals and objectives. Unlike the traditional "supply versus demand reduction" approach, the logic model acknowledges the inter-relatedness of drug programming efforts, particularly the relationship between criminal justice and treatment efforts that function to reduce both the supply of and demand for drugs. Second, the logic model emphasizes the critical need for cooperation and coordination among different levels of government. This is especially important in the case of the District in which the drug-related activities of the federal and other adjacent governments are inextricably linked.

The following Strategy represents a comprehensive, coordinated response to the serious threat posed by substance abuse and its consequences in the District. It provides an overview of current programming to address the problem and outlines steps to better focus its efforts. It establishes goals and priorities in the areas of programs and budget and sets forth a framework for enforcing accountability. This strategic approach is especially critical in the face of challenges posed by scarce resources. Spending priorities and targeted points of attack are realistically described in the context of existing District agency policies, plans, and budgets.

Strategic planning is an "organic" process, in which a formal feedback mechanism--or performance measurement system–is used to refine and enhance a strategic approach. (Strategic planning will be addressed in detail in Chapter 4). Nevertheless, the core underlying principles of the District's Substance Abuse Strategy will remain constant. We must attempt to prevent drug problems before they start. We must foster a compassionate response to the suffering of addicts and their families. We must ground a substance abuse strategy in a foundation of political will, beginning with the city's mayor and spreading out to the individuals at the neighborhood level. Finally, we must involve a network of stakeholders who are committed to the development, implementation, and monitoring of the Strategy.

It is the vision of both the mayor and the Task Force that this strategic plan becomes a model effort to inspire other cities with its methodology, planning, implementation, and success.

Chapter 2

THE DIMENSION OF THE DISTRICT'S SUBSTANCE ABUSE PROBLEM

FACING THE CHALLENGE

No single statistic captures the entire scale and scope of substance abuse in the District of Columbia. However, by piecing together a variety of substance abuse data "indicators," it is possible to gain a sense of the magnitude of the problem. In short, these figures portray a city in which the rates of alcohol and drug abuse are high, and in some cases, exceed the national average. Perhaps most troubling, these elevated rates of addiction are compounded by a serious shortage of treatment capacity.

The District's levels of substance abuse result in significant negative consequences, particularly with regard to the health and safety of the city's citizens. Substance abuse imposes considerable economic and social costs, including increased burdens on hospital, school, and child welfare systems. The cumulative effect of these consequences exacts a toll on all District residents and devastates certain segments of the population where rates of addiction and drug-related violence are highest.

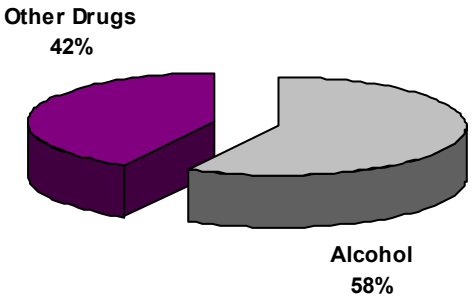
$1.2 BILLION IN SOCIAL COSTS

The social and economic costs of alcohol and drug abuse in the District of Columbia are staggering—possibly exceeding more than $1.2 billion per year or $2,100 per resident. These costs consist primarily of the value of lost productivity from substance abuse from such causes as premature deaths, criminal careers, substance abuse-related illnesses, and incarceration. They also reflect the health and crime consequences from substance abuse, both in the direct effects on the drug user and the community at large. Such costs include medical consequences of substance abuse from diseases such as tuberculosis, HIV/AIDS, hepatitis B and C, as well as the health costs of victims of drug-related crime. Figure 1 illustrates that approximately $700 million of the total $1.2 billion in social costs is attributable to alcohol use and approximately $500 million to other drugs.

Reducing the social costs of substance abuse requires a specific strategic plan, including targeted efforts to lower both current rates of addiction and what may be characterized as "initiation" or "recruitment" into addiction. This latter category of use involves the prevention of first-time use as well as reductions in so-called "casual drug use" before it progresses into more serious problems.

Figure 1

$1.2 Billion in Social Costs of Alcohol and Drug Abuse in the District of Columbia



Drug addiction and alcoholism contribute disproportionately to social costs. Research indicates that although the addict population represents only about 20 percent of the overall user population nationwide, addicts account for more than two-thirds of the consumption of illicit drugs. Similarly, those addicted to alcohol account for the bulk of

alcohol consumption. As top consumers of alcohol and other drugs, addicts and alcoholics commit the majority of crime, suffer the majority of health-related problems, and have the lowest productivity.

Addiction, however, does not fuel the entire substance abuse problem or its associated costs. Recreational drug and alcohol use, sometimes referred to as "casual" or "current drug use," entices new users to start using drugs and alcohol. This "casual user" is usually connected to a family, attends school or is employed, and projects a positive lifestyle. In epidemiological terms the "casual drug user" is a "carrier" of the disease of addiction who influences his or her peers to make unhealthy lifestyle choices. Casual drug use and its role in spreading addiction must be thoroughly examined and understood as a major contributing force to any given community's substance abuse problem.

SCALE OF OVERALL DRUG USE

A useful starting point in assessing the extent of the substance abuse problem in the District is to determine the magnitude of the substance-abusing population. For the purposes of making policy, it is helpful to consider the scale of the substance abuse problem in the context of general overall use rates (prevalence) and the number of "initiates" (individuals who are beginning to experiment with alcohol, cigarettes, and/or illicit drugs).

The 2000 District of Columbia Household Survey (Household Survey) developed estimates of overall prevalence by asking respondents about their drug-using activity in the 30 days before the survey, during the past year, and during their lifetimes. Such an approach captures all forms of drug-using behavior, from one-time use (sometimes referred to as experimentation), recreational use (non-dependence), to dependence. The survey questions only members of households about their use, which means that it tends to undercount rates of addiction because drug addicts and alcoholics often lead transitory lifestyles outside of stable household units. (As discussed later in this document, the Mayor's Interagency Task Force on Substance Abuse Prevention, Treatment and Control (Task Force) plans to obtain population-based estimates of the addict population in DC).

The Household Survey found that 41,000 or nearly 10 percent of District residents reported using an illicit drug in the 30 days before being interviewed (past-month basis).

Table 1

Percentage Reporting Substance Use on a Past-Month Basis

Age Group	Illicit Drugs	Alcohol	Cigarettes
12-17	7.4%	17.2%	12.1%
18-24	20.5%	64.8%	31.8%
25-34	14.0%	59.5%	25.6%
35+	6.4%	47.5%	25.9%
Total, All Age Groups	9.6%	50.1%	25.7%

Source: 2000 District of Columbia Household Survey on Substance Abuse.

It also revealed that an estimated 109,000 residents had used cigarettes and 73,000 individuals had engaged in binge drinking in the previous month. Table 1 presents data on the percentage of the population reporting illicit drug, alcohol, and tobacco use on a past-month basis (current or regular users). It shows that the highest rate of illicit drug use in the District occurs between the ages of 18 and 34. Among those between the ages of 18 and 24, specifically, the overall rate of drug

use is nearly 21 percent—meaning that one in five used illicit drugs on a past-month basis.

The number-one illicit "drug of choice" in the District is clearly marijuana. A significant number of residents, however, use cocaine. Other drugs, though less prevalent across all user groups, appear to be popular among certain segments of the population. For example, although many younger drug users did not report using either heroin or inhalants, both of these substances were being used by about 10 percent of drug users over the age of 35.

A resurgence of PCP (phencyclidine hydrochloride) use began in 2001 and continues today in the Northeast and Southeast sectors of the District as well as in nearby Prince George's County. Although PCP still lags behind marijuana and cocaine, a range of statistics marks its troubling increase. Detoxification patients in the District now test positive for PCP six times more often than in 1999. The Prince George's County police laboratory, which tests all drugs seized in the county, received more than 115 PCP samples in 2002–up from eight in 2000.

The Household Survey reveals dramatic differences in illicit drug use on the basis of gender, employment, and education. District males use illicit drugs at almost two and a half times the rate of females (14.0 percent for males compared with 5.8 percent for females). Rates of drug use were highest among those with a high school education or less (11.4 percent) compared with those with more education (8.6 percent for those with one to four years of college and 6.4 percent for those with graduate degrees). Rates of drug use also vary according to employment status. Nearly one of every four (24 percent) unemployed residents used an illicit substance on a past-month basis compared to 8.1 percent for those employed full time.

DISTRICT RATES OF ILLICIT DRUG USE 52 PERCENT HIGHER THAN THOSE OF THE NATION

The District's overall rates of substance abuse are higher than those of the nation as a whole. The overall illicit drug use rate of 9.6 percent in the District is a striking 52 percent higher than the nationwide rate of 6.3 percent for the same year. District youth, however, ages 12 to 17, report a *lower* rate of *illicit* drug use relative to young people throughout the United States.

DRAMATIC RATES OF ALCOHOL AND TOBACCO USE AMONG DISTRICT YOUTH

Unlike the comparatively low rates of illicit drug use for District youth, the Household Survey reveals dramatic rates of alcohol and tobacco use among this group. Although access to tobacco and alcohol is prohibited for individuals under the ages of 18 and 21, respectively, one in every three District adolescents between 12 and 17 years of age (34 percent) reported that they had used alcohol during their lifetime. Seventeen percent reported that they used alcohol on a past-month basis. Rates of past-month alcohol use were highest for young adults between 18 and 24 years old, with 77 percent reporting past-month use. With regard to tobacco, about one in 10 adolescents between the ages of 12 and 17 (12.1 percent) reported smoking cigarettes on a past-month basis; the rate jumps to almost 32 percent for those between the ages of 18 and 24.

For first-time drug use—"substance abuse initiation"—the Household Survey reveals that the onset of substance abuse is a more serious problem for the District than for the nation. Simply put: District residents report drug use initiation at an earlier age compared to those in the nation. This onset tends to occur early in the teen years. What is

most interesting, however, is that despite this earlier initiation, *prevalence* rates for the District among those ages 12 to 17 are lower than the rates for the nation. This suggests that the length of time of "conversion" from initiation to *prevalence* among those ages 12 to 17 in the District is longer than for the nation. Within the District, the average age of initiation for alcohol is 13.3 years compared to the national average of 16.3 years. That is, youth in the District initiate alcohol use a full three years earlier than youth across the nation. The finding for other substances is similar to that of alcohol. The average age of initiation for cigarettes is 13.7 years in the District compared with 15.4 for the nation. And the average age of initial marijuana use is 14.5 years, compared to 17.0 years for the nation.

Similar to the National Household Survey on Drug Abuse (recently re-named National Household Survey on Drug Use and Health), the District's Household Survey does not include individuals living on college campuses, an estimated 70,000 within the city. According to Metropolitan Police Chief Charles Ramsey, not only do drug and alcohol abuse on college campuses claim the lives of students every year, they also place an enormous demand on the city's enforcement resources. Clearly, effective strategic planning must target the substantial problem of drug and alcohol abuse on District college and university campuses.

60,000 ADDICTS IN THE DISTRICT

The Task Force estimates that approximately 60,000 District residents are addicted to alcohol and other drugs. This finding is supported by the Household Survey which revealed that rates of addiction in the District were nearly double the U.S. rate. As shown in Table 2, the survey of household residents reported an addiction rate of 8.9 percent—nearly one in ten District residents—compared to a nationwide rate of 4.7 percent. The primary drug of dependence in the District is alcohol. Illicit drug dependence tends to involve mostly cocaine—crack cocaine—but heroin and marijuana use are becoming increasing problems for the District.

A notable aspect of the District's substance abuse profile is the low rate of dependence among youth ages 12 to 17 as compared to young adults ages 18 to 24. Compared to the national average, rates of dependence among District youth are below the national average. Alcohol dependence is reported in the Household Survey to be 2.0 percent, compared to 3.6 percent nationwide; illicit drug dependence is 3.2 percent, compared to 5.7 percent nationwide. These results suggest that the current generation of youth in the District may understand the risks and dangers posed by drug and alcohol use. For young adults, aged 18 to 24, however, the findings are discouraging. Rates of dependence for alcohol were found to be 14 percent compared to 9.2 percent nationwide; illicit drug dependence was a startling 18.9

Table 2

Percentage Reporting Past-Year Dependence in the District Compared With the United States

	District of Columbia	United States
Illicit Drug/Alcohol	8.9%	4.7%
Alcohol	6.9%	3.7%
Cocaine	1.8%	0.3%
Heroin	0.6%	01.%
Marijuana	2.4%	1.0%

Source: District of Columbia 2000 Household Survey on Substance Abuse; 2000 National Household Survey of Drug Abuse.

percent compared to 11.9 percent nationwide. Young adults dependent on drugs and alcohol likely initiated drug use in the early 1990s when initiation nationwide exploded. Although the causes of the dramatic differences in dependence are not known, District youths and young adults represent both hope and concern for the future. Our challenge is to continue to educate all of the District's youth regarding the pitfalls of alcohol, tobacco, and drug use so that they make wiser and more informed choices. At the same time, we must encourage those whose choices have led them to addiction to seek and receive help.

CO-OCCURRING DISORDERS COMMONPLACE

Many individuals with substance abuse disorders have a co-occurring mental illness. According to federal estimates, 7 million to 10 million individuals in the nation have at least one mental disorder as well as an alcohol or other drug use disorder. According to the District's Department of Mental Health, there are 26,000 to 42,000 individuals with a co-occurring disorder in the District. The Department further estimates that at least 40 percent of the street-bound homeless population in the District has a co-occurring disorder.

Compared to individuals with either a serious mental disorder or a substance abuse problem, individuals with co-occurring disorders tend to have multiple health and social problems and require more costly care. Many are at increased risk of incarceration and homelessness. Co-occurring disorders are also a serious problem for children and youth. Researchers have found that a mental disorder often acts as a "gateway" to substance abuse.

MANY HOMELESS INDIVIDUALS STRUGGLING WITH ADDICTION

Substance abuse is also a major contributor to homelessness in the District. The lack of a stable and safe living environment means that the drug-dependent homeless individual is much more likely to relapse and remain addicted even after receiving treatment. Recent estimates suggest that on any given day there are approximately 7,225 individuals in emergency shelters, transitional housing on the streets, or awaiting shelter while staying in precarious housing. The Community Partnership for the Prevention of Homelessness estimates that on any given day, as many as 8,400 of 85,800 poor people in the District, or about one in 10, rely on the homeless continuum of care for shelter, housing, and services. They further estimate from a 2002 survey that there are approximately 2,600 chronic substance abusers in DC that are homeless. This figure represents 35 percent of the homeless population surveyed on that particular day.

Homeless individuals present a complex set of problems to service providers. Their needs include basic services from shelter, food, and clothing to supportive services, such as substance abuse and mental health treatment, health care, employment training, and other specialty needs. Although precise estimates of the number of homeless individuals struggling with addiction are not known, it is clear that the current homeless continuum of care does not meet the treatment service demand of this special population.

DISTRICT TREATMENT CAPACITY NOT EQUAL TO THE DEMAND: THE "TREATMENT GAP"

Drug treatment in the District is offered by public and private providers, including the

District government (public treatment), the federal government (for District residents in pretrial or on probation or parole), and private care available to those who have insurance and/or private means.

Recent treatment admission data indicate that the District's publicly funded treatment capacity is not adequate to meet the demand for services. It is estimated that about 8,500 individuals were admitted to substance abuse treatment in 2002. *This suggests that of the total 60,000 individuals needing treatment for a substance abuse problem, only about 14 percent of them received it. This "treatment gap" denies almost nine out of 10 individuals needing treatment.*

Admissions to publicly funded treatment in the District increased dramatically over the last decade. Table 3 shows total admissions increased by a factor of four between 1994 and 2002, from 1,360 annual admissions to 5,534 admissions. [Note: The discrepancy between the 5,534 figure in Table 3 and the 8,500 figure in the preceding paragraph is because APRA tabulates the total number of treatment *admissions* including repeat admissions of the same individual, whereas the U.S. Department of Health and Human Services tabulates only the total number of *individuals* served per year.] In 2002, the most recent year for which data are available, heroin was the primary substance of abuse at admission. This was followed closely by cocaine and alcohol.

Clearly, those who seek treatment should not be denied it because of a lack of capacity, especially in the case of adolescents who might benefit most from effective treatment programming. APRA is currently increasing treatment capacity to this severely underserved population.

Research has shown that addiction is a chronic disease that can be treated successfully with outcomes comparable to those of other chronic diseases. Although the District's new treatment voucher system adds a new core of treatment providers, there are nevertheless tremendous fiscal and managerial hurdles that must be overcome for "true choice" to occur; especially for the large number of individuals requiring costly long-term residential treatment. The challenge for the District is to expand the capacity of the treatment system to treat more addicts and to improve the effectiveness of existing services.

Table 3

Treatment Admissions in the District

Year	Total Admissions
1994	1,360
1995	1,471
1996	979
1997	2,885
1998	3,618
1999	6,056
2000	6,025
2001	5,755
2002	5,534

Source: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set, 1994-2002

DRUG-RELATED VIOLENT CRIME DECLINED OVER PAST DECADE

Drug use and criminal activities occur in an insidious cycle. First, simple possession of certain substances is a crime. Second, addiction to illicit drugs almost always leads to

Table 4
Reported Crimes in the District, 1993-2002

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Homicide	454	399	360	397	301	260	241	242	233	262
Sexual Assault	324	249	292	260	218	190	248	251	181	262
Robbery	7,107	6,311	6,864	6,444	4,499	3,606	3,344	3,553	3,777	3,731
Aggravated Assault	9,003	8,218	7,225	6,310	5,688	4,932	4,616	4,582	5,003	4,854
Burglary	11,532	10,037	10,192	9,828	6,963	6,361	5,067	4,745	4,947	5,167
Theft	31,466	29,673	32,281	31,343	26,748	24,321	21,673	21,637	22,274	20,903
Stolen Auto	8,060	8,257	10,192	9,975	7,569	6,501	6,652	6,600	7,970	9,168
Arson	200	206	209	162	150	119	105	108	104	109
Total	**68,146**	**63,350**	**67,615**	**64,719**	**52,136**	**46,290**	**41,946**	**41,718**	**44,489**	**44,456**

Source: Metropolitan Police Department, (2003)

other crimes, including robbery and assault, as addicts steal to finance their habits. Third, the psychoactive effect of drugs often triggers violence and fuels child abuse and neglect. Finally, a considerable amount of violence commonly accompanies the distribution of illegal drugs as dealers battle for market share.

Nowhere is the connection between criminal activity and substance abuse more apparent than in the rates of illicit drug use among the District's arrestees. Over half of adult males arrested in the District tested positive for illicit substances. For both adults and juveniles, about one-half of those arrested for a violent offense tested positive. Fully three-quarters of adult males charged with committing a property crime tested positive for an illegal drug; 45 percent tested positive for cocaine. Clearly, the District's future success in reducing crime and violence is closely linked to its success at reducing the drug problem.

No one can deny the substantial progress made by the District in reducing drug-related crime and violence in the last decade. Once labeled the murder capital of the nation, the number of homicides declined from 454 a decade ago to 262 in 2002. Washington and New York were among the few large cities where homicides actually declined between 2000 and 2001. However, a troubling 12 percent increase in homicides in the District from 2001 to 2002 must be noted. Homicides in several other major cities also climbed during this same time period. Although criminologists agree that these increases are still too recent to label as either trend or temporary, the Metropolitan Police Department is marshaling additional manpower to address the problem.

The reported number of crimes (Table 4) and the number of arrests (Table 5) fell by

Table 5
Arrests for Index Crimes in the District, 1996-2000

	1996	1997	1998	1999	2000
Homicide	216	187	181	124	128
Sexual Assault	136	205	199	151	181
Robbery	1,187	986	778	643	593
Aggravated Assault	2,923	3,232	2,799	2,222	2,187
Burglary	934	862	683	561	509
Theft	2,448	2,398	1,959	1,455	1,303
Stolen Auto	2,485	1,988	1,602	1,438	1,401
Arson	13	31	27	14	17
Total	**10,342**	**9,889**	**8,228**	**6,608**	**6,319**

Source: Metropolitan Police Department Research Unit

about 40 percent between 1996 and 2000, mirroring the trend in homicides. The number of arrests for substance abuse violations declined by about 17 percent (Table 6) during the period.

Table 6
Substance Abuse Arrests, 1996-2000

	1996	1997	1998	1999	2000
Sub. Abuse Arrests	10,117	9,823	9,006	8,899	8,422
All Arrests	58,872	71,487	63,026	59,009	57,151
% Share	17.2%	13.7%	14.3%	15.1%	14.7%

Source: MPD's Criminal Justice Information System (CJIS) data.

The District faces an enormous challenge to reduce drug distribution networks. The District's location on the I-95 corridor makes it vulnerable to a wide array of drug distribution schemes. An extensive highway system, plus three major airports and a major seaport are tempting opportunities for traffickers to move their products. Within the District, approximately 60 open-air drug markets have been identified that are controlled by drug "crews." The National Drug Intelligence Center's National Gang Survey 2000 identified 42 crews that distribute cocaine, with most of them also distributing heroin and marijuana. Located in low-income areas as well as along main corridors into and out of the District, these distribution markets know no bounds. Ongoing success in reducing drug-related crime requires that the District continue to target these groups through law enforcement and community outreach efforts.

HEALTH CONSEQUENCES

Substance abuse poses a substantial threat to the health of District residents with abuse one of the principal determinants of emergency room visits. A Drug Strategies report estimates that nearly 40 percent of all emergency room visits involve patients under the influence of drugs or alcohol. According to national research, more than two-thirds of those who are addicted will seek primary- or urgent-care every six months. Clearly, substance abuse contributes greatly to the District's health care costs.

Despite the 40 percent figure, the District has made progress in reducing the number of hospital emergency room episodes (person visits) and drug mentions (drugs in a person's system mentioned during the visit) as described in Table 7. Problems with cocaine have declined compared to a decade ago when the District was in the ravages of a crack epidemic, but it remains the most significant drug mentioned during an emergency room visit when illicit drugs are involved. Heroin, however, is re-emerging as a growing problem for hospital emergency rooms.

Substance abuse also plays a significant role in the spread of HIV/AIDS, hepatitis, and other diseases. Intravenous drug users are known to exhibit behaviors, including needle sharing, which place them at greater risk for disease. The Centers for Disease Control estimates that about one-third of all new HIV/AIDS infections are due to intravenous (IV) drug use. Targeting this population for treatment must be a priority if the District is to reduce the societal costs associated with their drug use.

The District is making progress in reducing substance abuse-related mortality. According to the District's Center for Health Statistics, substance abuse-related deaths are down by at least a third compared to almost a decade ago. This includes decreases in HIV/AIDS deaths as well as fewer alcohol-related liver disease deaths. Clearly, progress is

Table 7

Hospital Emergency Room Episodes and Drug Mentions for Illicit Drug Use

Year	Episodes	Mentions	Cocaine Mentions	Heroin Mentions
1993	12,339	21,692	4,275	1,414
1994	14,152	25,222	4,849	1,261
1995	11,830	19,896	3,542	1,307
1996	11,720	19,815	3,881	1,535
1997	11,194	18,975	3,223	1,691
1998	11,596	19,068	3,718	2,112
1999	10,282	16,947	3,150	1,794
2000	10,303	16,237	2,830	1,967

Source: Year-End 2000 Emergency Department Data from the Drug Abuse Warning Network

occurring in reducing health consequences of substance abuse, but much more work remains.

DAMAGING EFFECTS TO WOMEN, CHILDREN, AND FAMILIES

Substance abuse poses multiple risks for pregnant women, mothers, and their children. The use of alcohol, tobacco, and other drugs during pregnancy is a leading preventable cause of mental, physical and psychological impairments in infants and children. Children raised by substance abusers are more likely to experience neglect and abuse, poor school performance, depression, and delinquency, and comprise a large proportion of foster care placements.

SUBSTANCE ABUSE: A DISTRICT-WIDE PROBLEM

The Household Survey shows that the problems of substance abuse affect every neighborhood in the District, but not equally. Table 8 shows alcohol, tobacco, and illicit drug use by ward. With regard to illicit drug use, Wards 1, 2, 5, 7, and 8 reported rates of past- month use in excess of 10 percent with Ward 2 (14.1 percent) being the highest. According to the Household Survey, illicit drug use among adolescents and young adults (12 to 24 years of age) was higher in Ward 5 than in any other.

With regard to alcohol and tobacco use, geographic differences are stark. Ward 3 had the highest rate of residents age 12 and older reporting regular alcohol use. Alcohol use was relatively low in Ward 4. Adolescent and young adult alcohol use was found to be the lowest in Wards 6 and 7. Tobacco use was lowest in Ward 4 and highest in Ward 8.

CONCLUSION

The problem of substance abuse threatens the District's economic and social well-being. Nearly one in 10 District residents reports using an illicit substance on a past-month basis. One in five young adults between the ages of 18 and 24 use illicit drugs. Half of the District's population consumes alcohol and a quarter smoke cigarettes regularly.

Table 8

Past-Month Use of Alcohol, Tobacco, and Illicit Drugs, By Ward

Ward	Alcohol	Cigarettes	Illicit Drugs	Cocaine	Marijuana
1	51.7%	28.0%	12.6%	1.9%	10.1%
2	73.8%	25.8%	14.1%	1.9%	10.5%
3	76.8%	11.7%	2.7%	NA	0.3%
4	20.5%	7.8%	3.0%	0.6%	2.4%
5	42.8%	30.5%	14.0%	4.9%	12.5%
6	46.4%	30.1%	5.3%	2.7%	4.6%
7	38.8%	35.5%	12.3%	3.0%	6.3%
8	41.3%	41.8%	11.3%	3.3%	8.9%

Source: District of Columbia 2000 Household Survey on Substance Abuse.

These high rates of current drug use will, in time, swell the ranks of the District's addicted population that is currently estimated at 60,000. The rate of addiction in the District is nearly double the overall U.S. rate. The social and economic consequences associated with addiction cost the District approximately $1.2 billion annually. Although some long-term success in reducing the health and crime consequences of addiction has been achieved, the District's future depends on making additional progress and making it soon.

Chapter 3

THE DISTRICT'S SUBSTANCE ABUSE PROGRAMS AND BUDGETS

A RESOURCE ASSESSMENT

The District's efforts to reduce substance abuse involve a wide variety of activities that occur over a wide spectrum of agencies. Criminal justice agencies oversee the enforcement of drug laws. Health programs treat addicted individuals and support those who are homeless and burdened with additional diseases. Numerous agencies take part in prevention programs, most of which target special populations.

Accounting for substance abuse-related resources is a difficult task. Although some agencies and programs provide services with a "primary" substance abuse focus, most substance abuse-related expenditures are imbedded within larger programs whose primary focus is non-substance abuse-related. Because the specific substance abuse activity is often just one component of a larger program, these efforts often do not have specific dollar amounts attached that are readily identifiable in an agency's budget. Instead, expenditure levels must be estimated as a portion of their larger budget total. The goal is to estimate the level of effort devoted to substance abuse as a portion of the overall expenditures provided by the agency for its programs/activities. One approach to estimating substance abuse-related expenditures is to use workload measures. For example, if an agency is able to determine that about 30 percent of its workload is drug-related, then it is not unreasonable to assume that 30 percent of that agency's funds support substance abuse-related activities.

The Mayor's Interagency Task Force on Substance Abuse Prevention, Treatment and Control (Task Force), DC agency program officers, and DC budget officials worked together to develop the comprehensive inventory of substance abuse programs and activities presented in this chapter and Appendix B. The value of these substance abuse-related expenditure estimates is twofold. First, they provide a sense of the magnitude of total current efforts, as well as a description of how funds are distributed across different programmatic activities (e.g., treatment versus prevention). Second, and perhaps most importantly, this inventory provides an effective starting point for District agencies to improve coordination and address gaps in the system. Improved coordination will also allow the District to better leverage its available funding.

The Task Force will continue to refine its methodology for estimating total governmental expenditures in the District. For example, the figures contained in this chapter and the related budget appendix (i.e., Appendix B) do not fully account for the costs of alcohol beverage control. Nor do they include the costs of other activities, such as enforcement of tobacco laws prohibiting sales to minors or the substance abuse-related activities of the U.S. Attorneys in the District. The Task Force will continue to work with District agencies to refine and improve estimates of substance abuse-related government expenditures.

In addition, the estimates in this chapter and related budget appendix focus on the *direct* costs of prevention, treatment, law enforcement, and criminal justice efforts related to substance abuse. Direct costs of substance abuse include such things as the cost of drug treatment, drug education, or conducting narcotics investigations. Direct costs also include less obvious but equally important activities, such as referral to treatment, services needed to improve treatment outcomes (i.e., housing or employment counseling), and related administrative costs.

It is important to note that this chapter does not include the *indirect* "social costs" of substance abuse to the District, including lost worker productivity, driving fatalities, and increased infant mortality, just to name a few. Finally, there are the incalculable "costs" of substance abuse to the District in the form of untold human suffering and unrealized potential.

TOTAL SUBSTANCE ABUSE-RELATED PROGRAM EXPENDITURES:

$356 MILLION IN FY 2003

Total spending on substance abuse in the District is $356.1 million for FY 2003 (federal and local). Table 1 shows substance abuse expenditure estimates for FY 2003 and FY 2004 by Funding Source. The local portion ($288.5 million) represents 81 percent of total substance abuse-related expenditures. The federal portion totals $60.9 million, 17 percent. Expenditures from other sources total $6.6 million, or 2 percent. ("Other" sources of expenditures include monies the District receives for services or assessments that do not come from tax revenue.)

Table 1

Substance Abuse Program Expenditures
(dollars in millions)

Funding Source	FY2003	FY2004 Req/Est
District	$288.5	$289.0
Federal**	60.9	58.5*
Other/Unspecified	6.6	8.9
Total	**$356.1**	**$356.5**

* Based on current estimates of ongoing awards and formula grant funding. The estimate does not include potential new grant awards.
** US Bureau of Prisons figure not included, see full discussion of federal monies to District.

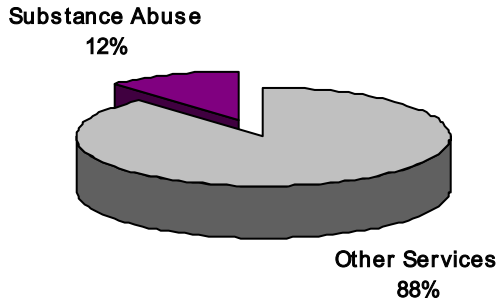
"PRIMARY" SUBSTANCE ABUSE PROGRAM EXPENDITURES: $53.3 MILLION

Programs whose primary focus is on substance abuse-related activities are located either in the Addiction, Prevention, and Recovery Administration (APRA), Court Services and Offender Supervision Agency's treatment program, or the Metropolitan Police Department's Narcotics Investigations Unit. In FY 2003, $53.3 million (15 percent) of the $356.1 million in total expenditures came from these agencies. Of the $53.3 million, only an estimated $34.5 million supports programs with a primary focus on substance abuse treatment.

Figure 1 shows that a vast majority of substance abuse-related expenditures ($313.9 million or 88 percent in FY 2003) is expended by agencies and programs with non-substance abuse specific missions (i.e., programs in which substance abuse-related activities are a

Figure 1

Substance Abuse Expenditures by Focus of Program



secondary focus). For example, the police make arrests of many individuals for drug-related crimes while conducting regular law enforcement activities, and the Department of Corrections houses inmates convicted of drug-related crimes. The Department of Mental Health provides services to people with mental health disorders often with co-occurring substance abuse. The DC Public Schools and the Department of Parks and Recreation provide substance abuse prevention services as part of much broader programming efforts.

Table 2 provides a breakdown by department and agency of substance abuse-related *local* (compared to federal) expenditures. With $150.6 million in DC expenditures, the Metropolitan Police Department (MPD) accounts for the largest share of expenditures in the city's substance abuse budget. Although all of the MPD's narcotics investigations are considered substance abuse-related, other enforcement activities that are related to substance abuse are also included. In addition, the MPD supports a number of prevention activities.

Table 2

District of Columbia
Substance Abuse Program Expenditures
FY 2003 – FY 2004
(millions of dollars)

DC Agency	FY 2003	FY 2004 Request
Children and Families Services Agency	$1.2	$0.9
Department of Health	25.4	22.9
Department of Human Services	5.3	5.4
Department of Mental Health	59.6	59.7
Metropolitan Police Department	150.6	153.7
DC Public Schools	3.7	3.7
Department of Corrections	42.6	42.6
Other	0.1	0.1
Total DC Agencies	**$288.5**	**$289.0**

The Department of Health manages the bulk of the District's treatment and prevention programs with $25.4 million in FY 2003. Within the Department, there are six components that support substance abuse-related services. APRA supports a variety of treatment and prevention efforts and accounts for $24.2 million in FY 2003. Other Department of Health components include the HIV/AIDS Administration and Medical Affairs/Communicable and Chronic Disease.

Other departments and agencies provide critical support to the overall substance abuse effort by the District. Of note, the Department of Human Services and the Children and Families Services Agency provide important support for treatment referrals and treatment for substance abuse. The DC Public Schools play an important role in the District's substance abuse prevention efforts.

The District of Columbia is not alone in its support of substance abuse-related services. The federal government supports the District's efforts to reduce substance abuse. In total, the federal government will provide the District government with $60.9 million of substance abuse-related funding in FY 2003 (Table 3). This represents roughly 17 percent of the total substance abuse budget for the District in FY 2003. The estimated funding level in FY 2004 is currently $58.5 million, a decrease of $2.4 million from FY 2003. The FY 2004 estimate likely understates the total federal funds the District will receive because of the way the FY 2004 estimate is calculated. The District receives funds through a variety of mechanisms including direct funding, formula grants, and discretionary grants. Changes in the factors used in determining the allocation of funding in formula grants can have unanticipated

consequences. Also, discretionary grants are typically awarded on a multi-year basis. Although the District anticipates that it will receive funding to continue ongoing grant programs, federal funds are awarded for the continuation of grants based on the availability of funds in any given fiscal year. In developing estimates for its substance abuse budget for FY 2004, no funding was included for federal discretionary grants scheduled to end in FY 2003. Likewise, no funding was included for possible new discretionary grant awards as decisions on these awards have not yet been made.

Table 3

Federal
Substance Abuse Program Expenditures
FY 2003 – FY 2004
(millions of dollars)

DC Agency	FY 2003	FY 2004 Estimate*
Court Services and Offender Supervision Agency	$11.1	$11.1
Department of Health	12.4	12.2
DC Housing Authority	0.9	---
Department of Mental Health	29.3	30.5
Metropolitan Police Department	4.2	3.1
DC Public Schools	1.5	0.3
Other	1.5	1.4
Total DC Agencies	**$60.9**	**$58.5**

* Based on current estimates of ongoing awards and formula grant funding. The estimate does not include potential new grant awards.

The Department of Mental Health will receive federal support for its programs and efforts totaling $29.3 million in FY 2003. Federal resources are used to support treatment for individuals with co-occurring substance abuse and mental health disorders.

The Court Services and Offender Supervision Agency (CSOSA) will receive $11.1 million in federal support in FY 2003. This federally funded office provides court services and supervision to individuals in the criminal justice system within the District of Columbia.

Several other departments receive substance abuse-related funding from the federal government. In FY 2003, the Department of Health will receive $12.4 million for treatment and prevention services, the MPD will receive $4.2 million primarily for law enforcement, the Department of Corrections will receive $0.3 million for treatment services, and the DC Housing Authority will receive $0.9 million for substance abuse prevention.

One large source of federal support to the District, which is not included in these estimates, is the U.S. Bureau of Prisons. In FY 2001 it was estimated that the Bureau of Prisons had expenditures of more than $166 million in support of District substance abuse-related services. These estimates were based on the costs for the incarceration of individuals convicted with substance abuse-related offenses. The Bureau of Prisons also provides substance abuse treatment to those in federal prisons who are in need of such services. Since the closure of the facility at Lorton, District inmates have been moved to many different federal facilities making it extremely difficult to develop an accurate estimate of federal support for these activities.

SUBSTANCE ABUSE EXPENDITURES BY FUNCTIONAL AREA

Although it is useful to know where the money comes from and which departments and agencies are providing substance abuse services, it is also important to understand exactly how the money is being used. To get a sense of the overall "balance," or focus, of substance abuse efforts in the District, Table 4 shows the distribution of expenditures according to four functional areas.

Table 4

Expenditures by Functional Area
FY 2003
(dollars in millions)

Activity	District Budget	Federal Resources*	FY2003 Total**
Law Enforcement	$150.6	$3.1	**$156.4** ***44%***
Corrections	39.2	---	**39.2** ***11%***
Treatment	90.6	51.6	**146.0** ***41%***
Prevention	8.0	6.2	**14.5** ***4%***
Total	**$288.4**	**$60.9**	**$356.1**

* Based on current estimates of ongoing awards and formula grant funding. The estimate does not include potential new grant awards.

** Includes "other" funding which is from sources other than the District Budget or federal resources.

The data in this table represents estimates only. The methodology required that expenditures for each program or activity be placed (in total) in only one functional category. Therefore, programs and activities that support more than one functional area have all expenditures allocated to the predominating function.

Law enforcement and corrections programs total more than $195.6 million (55 percent), substance abuse treatment accounts for $146.0 million (41 percent), and there is approximately $14.5 million (4 percent) for prevention-related services.

The dramatic share of law enforcement efforts in the $156.4 million expenditure total of Table 4 illustrates the central role that substance abuse and drug trafficking play with regard to criminal activity in the District. As Table 5 indicates, the number of arrests for drug law violations and alcohol-related offenses has fallen about 12 percent over the past five years, but they remain a significant share of MPD activity. Overall, these figures represent about 17 percent of all arrests.

Table 5

Substance Abuse Arrests, 1998-2002

	1998	1999	2000	2001	2002
Adults					
Drug Sales	937	1,544	1,149	1,538	1,478
Drug Poss.	5,218	5,128	5,063	4,793	4,482
DUI	2,112	1,579	1,593	1,615	1,332
Liquor law	200	106	139	287	306
Subtotal	8,467	8,357	7,944	8,233	7,598
Juveniles					
Drug Sales	94	122	95	128	106
Drug Poss.	444	419	381	318	251
DUI	0	0	0	1	0
Liquor law	1	1	2	2	0
Subtotal	539	542	478	449	357
Total	**9,006**	**8,899**	**8,422**	**8,682**	**7,955**
All MPD Arrests	**63,026**	**59,009**	**57,151**	**49,692**	**46,247**

Source: MPD's Criminal Justice Information System (CJIS) data.

Not surprisingly, individuals charged with and/or convicted of drug law offenses account for a significant share of the jail population. A census of DC correctional facilities conducted in September of 2001 revealed that 25 percent of the inmates were being held for violations of drug laws or for charges related to alcohol abuse (e.g., driving while intoxicated).

Criminal justice agencies also provide drug testing services and a substantial amount of treatment. For example, the Department of Corrections provides substance abuse counseling to inmates. CSOSA uses drug testing to monitor drug use among arrestees, individuals awaiting trial, and those on probation. In addition, CSOSA provides treatment to those testing positive. Finally, the DC Superior Court provides some testing and treatment services to arrested juveniles.

The cost of treatment and prevention programs in the District totals $160.5 million in FY 2003 (45 percent of the total substance abuse budget). However, it must be clearly understood that the $160.5 million includes an extensive collection of programming that targets substance abuse secondarily to other issues. Only $34.5 million of the $160.5 million is dedicated solely to the direct provision of substance abuse treatment to District residents. APRA oversees the provision of these treatment prgrams. In the fiscal year ending 2001, there were 7,500 admissions to these APRA programs. In FY 2002 the number of admissions increased to 8,500. APRA expects to admit the same number of people in FY 2003. (Note: APRA counts the total number of admissions with some clients being admitted, and counted, more than once.) In addition to APRA, several other District agencies contract for treatment services.

There are 10 departments or agencies that support substance abuse prevention services. Although prevention services are spread throughout the District Government, the expenditures for these programs tend to be considerably more limited than the funds provided for the other functional areas. The District of Columbia Public Schools ($5.2 million in FY 2003), Department of Health ($3.1 million in FY 2003), and the Department of Human Services ($2.9 million in FY 2003) have the largest expenditure levels associated with their substance abuse prevention efforts. The DC Housing Authority oversees three programs designed to reduce substance abuse and violence in public housing.

INVENTORY OF SUBSTANCE ABUSE-RELATED SERVICES AND RESOURCES

To get a complete picture of all contributions to the overall effort to reduce substance abuse and its consequences in the District of Columbia, refer to Appendix B, which features summaries of all expenditures and activities by department and agency.

Table 6 summarizes the estimates cited in this chapter as well as in Appendix B. This table provides a summary as well as a functional breakdown (i.e., prevention, treatment, and law enforcement) of department and agency expenditure totals.

Table 6

DC Substance Abuse Expenditures -- Summary Tables

Department/Agency Totals

(dollars in thousands)

	FY 2003				FY 2004			
	Local	**Federal**	**Other**	**Total**	**Local**	**Federal**	**Other**	**Total**
Department/Agency Totals								
Children & Families Services Agency	1,244.766	613.093	---	1,857.859	938.000	462.000	---	1,400.000
Court Services & Offender Supervision Agency	---	11,100.000	---	11,100.000	---	11,100.000	---	11,100.000
Department of Corrections	42,646.104	334.870	---	42,980.974	42,646.104	334.870	---	42,980.974
Deparment of Health	25,354.232	12,377.325	885.190	40,919.089 *	22,851.929	12,186.545	390.000	37,708.816 *
DC Housing Authority	---	850.000	---	850.000	---	---	---	---
Department of Human Services	5,293.338	497.993	---	5,791.331	5,361.666	529.593	---	5,891.259
Department of Mental Health	59,615.270	29,291.456	770.000	89,676.726	59,722.749	30,465.253	---	90,188.002
Metropolitan Police Department	150,617.413	4,247.539	2,669.100	157,534.052	153,742.043	3,090.837	6,249.600	163,082.480
Neighborhood Services	---	---	---	---	---	---	---	---
OCC / Criminal / Juvenile	2.500	---	---	2.500	1.000	---	---	1.000
Department of Parks & Recreation	44.300	---	---	44.300	41.000	---	---	41.000
DC Public Schools	3,719.491	1,507.101	---	5,226.592	3,719.491	286.101	---	4,005.592
DC Superior Court	---	81.000	---	81.000	---	85.000	---	85.000
Total, DC Substance Abuse Budget	**288,537.414**	**60,900.377**	**4,324.290**	**356,064.423**	**289,023.982**	**58,540.199**	**6,639.600**	**356,484.123**
Funding not identified as Local/Fed/Other				***2,302.342***				***2,280.342***

Table 6

DC Substance Abuse Expenditures -- Summary Tables

Department/Agency Totals

(dollars in thousands)

	FY 2003				FY 2004			
	Local	**Federal**	**Other**	**Total**	**Local**	**Federal**	**Other**	**Total**

Function Tables

(dollars in thousands)

	FY 2003				FY 2004			
	Local	**Federal**	**Other**	**Total**	**Local**	**Federal**	**Other**	**Total**
Prevention								
Deparment of Health	632.656	2,350.741	156.000	3,139.397	662.802	24.505	156.000	843.307
DC Housing Authority	---	850.000	---	850.000	---	---	---	---
Department of Human Services	2,576.840	369.424	---	2,946.264	2,645.168	401.024	---	3,046.192
Department of Mental Health	1,074.689	---	---	1,074.689	1,182.168	---	---	1,182.168
Metropolitan Police Department	---	1,170.092	---	1,170.092	---	875.000	---	875.000
Neighborhood Services	---	---	---	---	---	---	---	---
OCC / Criminal / Juvenile	2.000	---	---	2.000	.500	---	---	.500
Department of Parks & Recreation	44.300	---	---	44.300	41.000	---	---	41.000
DC Public Schools	3,719.491	1,507.101	---	5,226.592	3,719.491	286.101	---	4,005.592
DC Superior Court	---	2.000	---	2.000	---	2.500	---	2.500
Subtotal, Prevention	**8,049.976**	**6,249.358**	**156.000**	**14,455.334**	**8,251.129**	**1,589.130**	**156.000**	**9,996.259**
Funding not identified as Local/Fed/Other				**---**				**---**
Treatment								
Children & Families Services Agency	1,244.766	613.093	---	1,857.859	938.000	462.000	---	1,400.000
Court Services & Offender Supervision Agency	---	11,100.000	---	11,100.000	---	11,100.000	---	11,100.000
Department of Corrections	3,405.827	334.870	---	3,740.697	3,405.827	334.870	---	3,740.697
Deparment of Health	24,721.576	10,026.584	729.190	37,779.692 *	22,189.127	12,162.040	234.000	36,865.509 *
Department of Human Services	2,716.498	128.569	---	2,845.067	2,716.498	128.569	---	2,845.067
Department of Mental Health	58,540.581	29,291.456	770.000	88,602.037	58,540.581	30,465.253	---	89,005.834
OCC / Criminal / Juvenile	.500	---	---	.500	.500	---	---	.500
DC Superior Court	---	79.000	---	79.000	---	82.500	---	82.500
Subtotal, Treatment	**90,629.748**	**51,573.572**	**1,499.190**	**146,004.852**	**87,790.533**	**54,735.232**	**234.000**	**145,040.107**
Funding not identified as Local/Fed/Other				***2,302.342***				***2,280.342***
Enforcement								
Metropolitan Police Department	150,617.413	3,077.447	2,669.100	156,363.960	153,742.043	2,215.837	6,249.600	162,207.480
Subtotal, Enforcement	**150,617.413**	**3,077.447**	**2,669.100**	**156,363.960**	**153,742.043**	**2,215.837**	**6,249.600**	**162,207.480**
Funding not identified as Local/Fed/Other				**---**				**---**
Corrections								
Department of Corrections	39,240.277	---	---	39,240.277	39,240.277	---	---	39,240.277
Subtotal, Corrections	**39,240.277**	**---**	**---**	**39,240.277**	**39,240.277**	**---**	**---**	**39,240.277**
Funding not identified as Local/Fed/Other				**---**				**---**
Total, DC Substance Abuse Budget	**288,537.414**	**60,900.377**	**4,324.290**	**356,064.423**	**289,023.982**	**58,540.199**	**6,639.600**	**356,484.123**
Funding not identified as Local/Fed/Other				***2,302.342***				***2,280.342***

* The total includes expenditures for which the source of funding was not identified.

Chapter 4

STRATEGIC GOALS AND OBJECTIVES

PRINCIPLES OF A COMPREHENSIVE, BALANCED STRATEGY

This urban-based Substance Abuse Strategy (the Strategy) is built on the premise that no single approach can end substance abuse or its damaging consequences. Its strategic goals and objectives involve a wide spectrum of public agencies and private entities, including prevention, treatment, and law enforcement communities. In addition to the District's efforts to mobilize against substance abuse, the actions of the federal government, adjacent regional governments, private organizations, and individual residents are all critical to the achievement of strategic goals and outcomes. Accordingly, this Strategy proposes that a comprehensive approach to reducing substance abuse be carried out via a partnership among the District government and all those who have a stake in the results: District residents, the federal government, Virginia and Maryland inter-governmental agencies, the faith community, as well as non-profit and private organizations.

FRAMING A STRATEGIC APPROACH

Every strategic framework employs certain perspectives, terminology, and approaches. This Strategy, by order of the mayor, encompasses activities aimed at reducing not only alcohol and drug use, but underage tobacco use as well. Of course, tobacco and alcohol are legal substances to those over the ages of 18 and 21, respectively. From a strategic planning standpoint, therefore, this Strategy appropriately targets the demand and availability of tobacco and alcohol for those underage individuals. Furthermore, it focuses only on the *abuse* of alcohol and the damaging effects of tobacco use by those of legal age. The charge of this strategic framework, then, is to target the use and availability of all illicit substances (such as cocaine and heroin), the abuse of legal substances (e.g., alcohol, tobacco, and prescription drugs), and the use and availability of tobacco and alcohol that are prohibited to those under the ages of 18 and 21, respectively.

This strategic framework uses the terms *goals, objectives, performance targets,* and *performance measures*. "Goals" define the major directives of the Strategy. In this strategic plan, four goals represent four major strategic areas: prevention, treatment, criminal justice, and intergovernmental coordination. "Objectives" define major activities required to achieve the desired goal. "Performance targets" define desired end-states, outcomes, or results to track the success of the strategic plan. "Performance measures" refers to the metric, data, or information used to track progress toward the achievement of a given performance target.

This Strategy utilizes a systems approach. The reasons are several. First, a substance abuse strategy should encompass all members of a community who have a stake in its outcome. Accordingly the Mayor's Task Force on Substance Abuse Prevention, Treatment and Control (Task Force) will continue to consult with a diverse community of stakeholders on how best to achieve a set of desired ends. In addition, the Strategy will inform the budget process about resource needs. And finally, the Strategy will be grounded in a formal feedback mechanism—a performance measurement system—to report progress in achieving results. These results will, in turn, be provided to the community of stakeholders and used as a basis for subsequent refinements to the Strategy.

The strategic framework for the District's Substance Abuse Strategy consists of three basic building blocks. The first is demand reduction, which involves treatment and prevention activities. The second is criminal justice, which involves activities from policing and incarceration to probation and parole. And the third is activities of overlapping and adjacent governments whose policies and programs affect the District's ability to manage its substance abuse problem.

These three building blocks shape the parameter of the District's strategic plan. Consider the role of law enforcement. It is much more than just policing. It is the means by which many in the drug trade become involved in the District's criminal justice system. For dealers, this involvement translates into incarceration and it is hoped rehabilitation as well as reduction in the supply of drugs. For users, the criminal justice system can provide the means to begin a recovery process through court-ordered treatment. For those individuals, especially youth, who are involved in both drug selling and using, a treatment and criminal justice response must include coordinated educational and training opportunities.

Demand reduction is the best option to reduce the size of the existing substance abuse problem—mostly by targeting addiction through treatment programming and by discouraging potential new users from ever picking up illicit and illegal substances through effective prevention efforts. To achieve results, the Strategy must take into account both the demand and supply reduction activities of the federal government, which operates programs within the District, as well as the activities of adjacent governments whose policies can ameliorate or burden the District's efforts to confront its substance abuse problem.

For the purposes of comparison, it is useful to examine the strategic approach utilized by the federal government's National Drug Control Strategy in its effort to reduce drug use and its consequences nationwide. The National Drug Control Strategy seeks to reduce drug use and its consequences through extensive activities that encompass prevention, treatment, international programs, interdiction, and law enforcement. The District's drug control Strategy is necessarily less ambitious in scope because the focus is on a limited geographic urban area and international program activities and efforts to target drug supplies through interdiction are quite obviously and constitutionally outside the scope of this or any other local strategy. But like the National Drug Control Strategy, the District's Strategy employs research-based approaches to prevention and treatment and a performance measurement system to determine progress toward achieving desired goals and objectives.

FOUR STRATEGIC GOALS

The Task Force initiated an extensive consultation process to develop a comprehensive strategic substance abuse control framework for the District. After receiving input and perspectives from members of the prevention, treatment, and law enforcement communities, including representatives of the federal government directly involved in District affairs, and outside drug control experts, the following four strategic goals and 20 objectives were identified in the context of measurable performance targets or outcomes to track progress along the way. The Task Force will continue to oversee an ongoing consultation process to implement the Strategy and refine it as necessary.

Goal 1: Educate and empower District of Columbia residents to live healthy and drug-free lifestyles.

Objectives:

Expand prevention activities through coalitions and neighborhood organizations.

Increase the effectiveness of prevention activities through the

development and strengthening of a planning, implementation, and evaluation infrastructure.

Increase the utilization of appropriate evidence-based prevention programs.

Utilize evidence-based environmental strategies to change individual and community norms.

Increase the effectiveness of the District's prevention workforce by training youth development and prevention professionals to implement effective prevention strategies.

Prevention efforts are not only morally correct, they are cost effective. This Strategy seeks to secure the District's social and financial future by encouraging its youth to engage in healthy and substance abuse-free lifestyles. This means that initiation and existing causal use (non-addictive drug use) must be strongly discouraged and successfully abated. The Strategy seeks to prevent potential users from ever starting to use drugs, alcohol, and tobacco. It seeks to get those who have tried drugs to stop their experimentation. Success with these individuals will mean fewer individuals addicted to substances in the future.

Goal 2: Develop and maintain a continuum of care that is efficient, effective, and accessible to individuals needing substance abuse treatment.

Objectives:

Increase long-term treatment capacity, especially for youth and women with children.

Increase the management effectiveness and efficiency of APRA.

Improve the treatment infrastructure by providing staff development through technical assistance and training.

Develop an accessible, integrated continuum of care containing all the necessary components, including aftercare, for individuals needing substance abuse treatment.

Develop a District-wide performance accountability system for treatment programs to support continuous quality improvement.

Addiction is a chronic disease. Substance abusers engage in treatment to recover from their addiction, but may experience relapse. A continuum of care connects programs and services starting with an individual's initial assessment and ending with the provision of support services to promote stability and to enable a successful return into the community. The objective of the continuum of care is to eliminate or reduce relapse duration and severity by addressing an individual's psychological, biological, economic, and social needs. Special populations require approaches that consider ethnic, cultural, language, sexual, and age diversity. It is premised on a "no wrong door" approach whereby those entering the treatment continuum at any point can access appropriate and effective services. Key to this placement is accurate assessment of the problem, including identification of co-occurring disorders and other issues, such as homelessness. Equally important are agency coordination, case management, and other "linkage mechanisms" by which to connect individuals with the appropriate services.

Goal 3: Increase the public's safety and improve treatment access for offenders to ensure fair and effective administration of justice in the District.

Objectives:

Reduce the number of open-air drug markets.

Form community-police partnerships to enhance neighborhood problem solving.

Strengthen the ability of law enforcement to anticipate and respond to drug-related crime.

Support the expansion of drug courts.

Improve case management of defendants/offenders and their transition

back into the community, including re-entry support services.

Develop law enforcement and prosecutorial opportunities to divert non-violent youth to alternative community-based interventions.

Ensuring the public's sense of safety requires an aggressive and coordinated law enforcement effort that targets drug dealing. For those users who come in contact with the criminal justice system, there must be opportunities for treatment and rehabilitation guided by the principle of personal accountability and responsibility for one's own recovery. And for those who commit violent crimes, there must be certainty of punishment. Moreover, since addicted drug users account for over two-thirds of the consumption of illicit drugs, targeting them for treatment via the criminal justice system will, in turn, reduce consumption and improve efforts to reduce drug dealing and the associated social costs.

Goal 4: Encourage a coordinated and focused regional response to the problem of substance abuse.

Objectives:

Promote regional resource sharing and opportunities for joint initiatives through partnerships among federal, state, county, and District drug control agencies.

Foster the adoption of consistent and mutually supportive anti-substance abuse laws and policies across jurisdictions.

Identify and remove barriers to treatment across jurisdictions.

Overall success of this Strategy will require the commitment of the entire metropolitan Washington area. The goals and objectives of this Strategy reflect an effort to solicit many ideas on how to improve community involvement and coordination. Remarkably, the Task Force discovered that numerous members of treatment, prevention, and the criminal justice systems had never been involved in joint drug control strategic planning. Their joint participation in this effort has produced a comprehensive, balanced plan. In addition, the Task Force has reached out to the Metropolitan Washington Council of Governments, including their prevention and treatment subcommittees, to develop cooperation among the Maryland, Virginia, and DC government agencies in the areas of policy and program planning and development, program coordination and support, and education and information.

FOCUSING ON RESULTS

This Strategy focuses on reducing the immediate drug problem on two fronts: reducing the number of addicts in the District and reducing the size of the potential problem by discouraging new and existing "casual" drug use. Success on these two fronts will translate directly into reductions in the consequences of substance abuse as represented by a reduction in its social costs. As has been previously noted in Chapter 1, this Strategy seeks to achieve two overarching goals by the year 2010: a 25,000 reduction in the number of addicts from the estimated current level of 60,000 addicts (Figure 1) and a reduction of the annual social costs of addiction by $300 million (Figure 2).

Figure 1

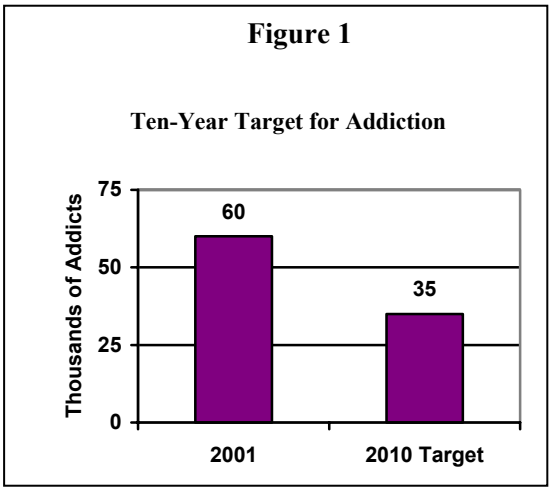
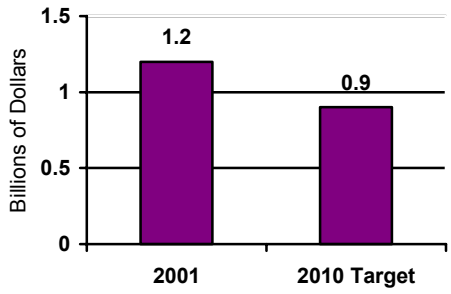
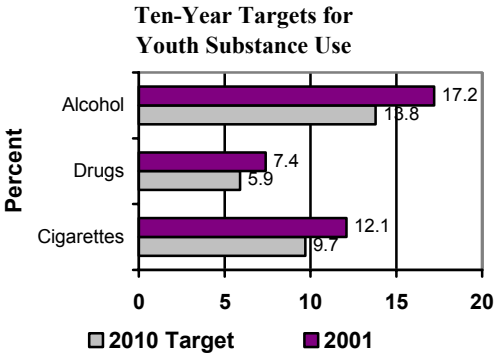


Figure 2



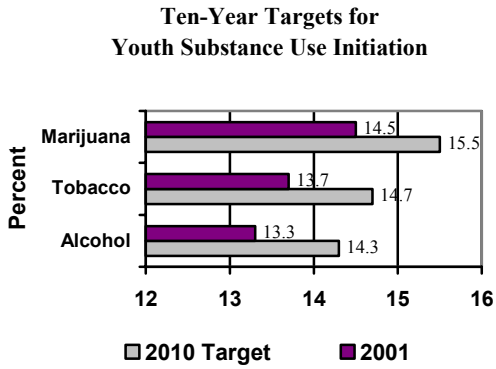
With regard to overall rates of substance use among District youth ages 12 to 17, this Strategy seeks to reduce this population's substance abuse prevalence by 20 percent (Figure 3). In light of the encouraging data for youth substance use initiation in the District, this Strategy seeks to further increase the average age of new substance use initiation for alcohol, tobacco, and marijuana by one year (Figure 4).

Figure 3



Achieving results will require a focus on three aspects of substance abuse: addiction, youth drug use, and social costs. These three categories will be used to track the success of the District's global substance abuse control efforts represented by this Strategy. Ultimately, however, the success of this Strategy requires the positive contribution of city agencies, private groups and organizations, individuals, and the successful coordination of substance abuse efforts within the metropolitan area. District agencies will track the progress of their individual efforts using their respective agency performance plans. In addition, the Task Force will monitor individual agencies by tracking their progress toward achieving respective performance milestones.

Figure 4



The Task Force will report biennially (once every two years) to the mayor on whether this Strategy is achieving its anticipated results.

MEASURING PERFORMANCE

The District will systematically measure progress for the three performance outcome areas: reducing addiction, youth drug use (new use and prevalence), and social costs.

The Addiction Prevention and Recovery Administration (APRA) will be responsible for reporting to the Task Force biennially on progress in achieving these outcomes. The Task Force will meet quarterly to consider policy and program matters related to the District's Substance Abuse Strategy. It will then prepare an annual report for the mayor

describing progress against the performance targets, program and policy concerns, and the resource needs to achieve results.

With regard to tracking progress against the performance targets, the Task Force will use the following sources of information:

- **District Household Survey on Substance Abuse**—This survey will be used to report progress toward reducing youth drug use. The Household Survey will be conducted biennially and will report drug use initiation and prevalence for youth ages 12 to 17. The 2001 Survey, released in September 2001, will serve as the baseline against which to measure progress. The second Household Survey results are planned for fall 2004.

- **The Social Costs of Drug Abuse in the District of Columbia**—APRA will have biennial studies conducted to determine changes in the size and composition of social costs in the District. APRA will establish a methodology for the District with results expected by spring 2005.

- **Estimates of the Number of Addicts**—APRA will report biennially on the number of addicts in the District who need treatment. To accomplish this, APRA will identify a methodology to estimate the size of the addict population in the District and will report an estimate to the Task Force by spring 2005.

In addition, APRA will prepare a biennial report delineating the size of the "treatment gap" in the District and the progress of the new treatment voucher system to address it. This report will assist the Task Force in identifying program and resource options to most effectively close the "treatment gap." Treatment need and capacity will include the requirements of the criminal justice system, which manages drug offenders in prison and jail as well as on parole and probation.

Strategic Goals and Objectives

SUMMARY

GOAL #1: EDUCATE AND EMPOWER DISTRICT OF COLUMBIA RESIDENTS TO LIVE HEALTHY AND DRUG-FREE LIFESTYLES

- Expand prevention activities through the use of a broad cross-sector advisory group as well as through coalitions and neighborhood organizations.
- Increase the effectiveness of prevention activities through the development and strengthening of a planning, implementation, and evaluation infrastructure.
- Increase the utilization of appropriate evidence-based prevention programs.
- Utilize evidence-based environmental strategies to change individual and community norms.
- Increase the effectiveness of the District's prevention workforce by training youth development and prevention professionals to implement effective prevention strategies.

GOAL #2: DEVELOP AND MAINTAIN A CONTINUUM OF CARE THAT IS EFFICIENT, EFFECTIVE, AND ACCESSIBLE TO INDIVIDUALS NEEDING SUBSTANCE ABUSE TREATMENT

- Increase long-term treatment capacity, especially for youth and women with children.
- Increase the management effectiveness and efficiency of APRA.
- Improve the treatment infrastructure by providing staff development through technical assistance and training.
- Develop an accessible, integrated continuum of care containing all the necessary components, including aftercare, for individuals needing substance abuse treatment.
- Develop a District-wide performance accountability system for treatment programs to support continuous quality improvement

GOAL #3: INCREASE THE PUBLIC'S SAFETY AND IMPROVE TREATMENT ACCESS FOR OFFENDERS TO ENSURE FAIR AND EFFECTIVE ADMINISTRATION OF JUSTICE IN THE DISTRICT

- Reduce the number of open-air drug markets.
- Form community-police partnerships to enhance neighborhood problem solving.
- Strengthen the ability of law enforcement to anticipate and respond to drug-related crime.
- Support the expansion of drug courts.
- Improve case management of defendants/offenders and their transition back into the community, including re-entry support services.
- Develop law enforcement and prosecutorial opportunities to divert non-violent youth to alternative community-based interventions.

GOAL #4: ENCOURAGE A COORDINATED AND FOCUSED REGIONAL RESPONSE TO THE PROBLEM OF SUBSTANCE ABUSE

- Promote regional resource sharing and opportunities for joint initiatives through partnerships among federal, state, county, and District drug control agencies.
- Foster the adoption of consistent and mutually supportive anti-substance abuse laws and policies across jurisdictions.
- Identify and remove barriers to treatment across jurisdictions.

Chapter 5

POLICY AND PROGRAM PRIORITIES

ACHIEVING RESULTS

This Substance Abuse Strategy (Strategy) is built on extensive stakeholder input from formal surveys, focus groups, neighborhood forums, and meetings with city and federal government substance abuse experts. The deliberations of the Strategy Working Groups (Working Groups) and public stakeholder input over two years has resulted in the addition, deletion, and extensive refinement of the Strategy's proposed goals and objectives. Chapter 5 describes current substance abuse programs and presents stakeholder-generated policy ideas and approaches. In some cases, the chapter highlights the tough substance abuse policy challenges that the District must resolve. Among them, the proper balance between law enforcement, treatment, and prevention spending and the effective implementation of the Choice in Drug Treatment legislation.

Chapter 5, along with the inventory of substance abuse-related services and resources in Chapter 3, will serve as a guide for the Working Groups to proceed with "action plans" for Strategy implementation. In the coming months, the Working Groups, with continuing stakeholder input, will formulate action plans for each of the Strategy objectives by logically outlining what activities and outputs should occur, by whom, and by when. Ultimately, the Task Force will use the action plans to hold individual agencies accountable for achieving the articulated Strategy performance targets or desired outcomes for 2010.

REDUCING PREVALENCE AND INCIDENCE OF SUBSTANCE ABUSE

Goal 1: Educate and empower District of Columbia residents to live healthy and drug-free lifestyles.

The prevention Working Group brought together a wide range of individuals and organizations within the prevention community. The Mayor's Youth Substance Abuse Prevention Advisory Committee (MYSAPAC) spearheaded the meetings. Established by mayor's order on August 17, 1999, MYSAPAC is responsible for the quality of prevention programming as well as legislative and budgetary policy for youth. Over the course of many meetings, numerous items were proposed, debated, and refined. Of greatest concern was the need to intervene with youth to prevent the early onset of drug use.

MYSAPAC is not only responsible for spearheading the working group meetings, it is also responsible for advising the mayor and the Department of Health, [including the Addiction Prevention and Recovery Administration (APRA)] on an ongoing basis. MYSAPC advises on the nature and extent of substance abuse, narcotics addiction and drug dependency, quality of prevention and rehabilitation programs, and other drug abuse-related issues as they pertain to District youth. The committee also promotes community interest and involvement in addressing the problems of youth drug abuse through awareness, education, and community-based processes.

Objectives:

Expand prevention activities through the use of coalitions and neighborhood organizations.

Community coalitions and neighborhood organizations play an important role in the prevention of substance abuse in the District. These organizations often work directly with youth and are a valuable source of information and support. By continuing to work with stakeholders and the community, the District will be able to deliver services more effectively and better serve its residents most in need of services.

Increase the effectiveness of prevention activities through the development and strengthening of a planning, implementation, and evaluation infrastructure.

Prevention is most effective when it is tailored to the needs of the community. A comprehensive planning and evaluation infrastructure will allow the District to serve its residents more effectively. A strong infrastructure will enable District government planning to be based upon ongoing consultation with residents as well as data-driven needs assessments. These methods will allow the District to select programs and services that are a good fit with the needs of its residents. Comprehensive needs assessments also help the District to select programs that require less "adaptation" or tailoring to local needs, which in turn increases their likelihood of reducing youth substance abuse.

The District will also increase the accountability of its prevention programming through the continued evaluation of its programs and strategies. This ongoing evaluation process will help District agencies with prevention responsibilities to analyze their efforts and achieve the proper balance between the enforcement of rigorous program standards and the flexibility required in tailoring programs to specific populations and locales.

Furthermore, the District government will utilize focus group testing with varied youth populations to provide feedback on its planned programs, initiatives and products. In addition, the youth advisory groups established by other government and private sector agencies will be used to provide additional guidance in the selection, implementation, and evaluation of prevention programs.

Increase the utilization of appropriate evidence-based prevention programs.

Research has demonstrated that prevention is an effective means of reducing substance abuse and related problems. MYSAPAC is identifying appropriate evidence-based prevention programs, approaches, and strategies to enable District youth to make healthy lifestyle choices. Under the auspices of the State Incentive Grant (SIG) program, a federally funded grant that works to replicate evidence-based drug prevention strategies, the District supports 10 science-based programs at a current cost of $1.8 million. The District funds programs ranging from life skills training, to family strengthening, to individual counseling services. The District also delivers in-home prevention programs aimed at increasing the bonds between parents and children. To further these efforts, APRA will work with other agencies with prevention activities to double the number of appropriate evidence-based programs in the city by fall 2005 and will also continue to support promising programs indigenous to the District.

The District plans to support innovation and flexibility in its substance abuse prevention activities by creating an infrastructure for programs that have not yet been evaluated rigorously enough to be considered evidence-based. The flexibility may better serve the distinct needs of District residents. The District's commitment to innovative programs also includes a commitment to provide additional evaluation expertise to help programs find the right balance between "fidelity" to rigorous

standards and adaptation to specific District populations and locales.

In addition to the evidence-based SIG programs, evidence-based programs have been put in place for at-risk youth and youth in need of peer support. Youth who drop out of school and/or have interfaced with the juvenile justice system are at particular risk for substance abuse and other serious problems. APRA has established peer support services for youth in drug court programs as well as juvenile probation oversight that provides access to prevention, treatment, and intervention education through weekly sessions at the Southeast juvenile probation center. APRA is also piloting several peer-to-peer support initiatives, which have been proven to be an effective form of prevention programming in many communities. Activities include peer-leadership programs, a youth directed Web site, and youth-to-youth communications, such as posters, wallet cards, and other media.

Consistent with evidence-based practices, APRA's Office of Special Populations Services (OSPS) will review and comment on all APRA prevention efforts before solicitation, award, and implementation. This will ensure that funding supports services that are responsive and accessible to the District's at-risk population by addressing ethnic, cultural, language, sexual (i.e., gay, lesbian, bisexual and transgender), and age diversity. Furthermore OSPS will review programs to ensure that the appropriate co-factors are addressed, including but not limited to mental illness, risky sexual behavior, and infectious disease. OSPS will also provide ongoing technical assistance and monitoring of APRA prevention efforts to support continued assurance of service responsiveness to diversity.

Utilize evidence-based environmental strategies to change individual and community norms.

Social marketing has proven effective in influencing individual behavior and societal norms, e.g., designated drivers campaigns. APRA is currently funding two projects: one targeting youth ages 12 to 17 and the second targeting 18 to 24 year-olds with substance abuse prevention messages. APRA will also identify additional media opportunities to educate District youth and other special populations. This could include media campaigns on the benefits of substance free lives or targeted campaigns aimed at preventing pre-natal alcohol use and other unhealthy behavior.

APRA will seek to increase media advocacy of healthy substance-free lifestyles by briefing the media and establishing a media task force. These briefings will provide the media with information on the scope of the District's substance abuse problem, APRA's programs, and costs of substance abuse to the District. To achieve these goals and to better inform the community of its work, APRA has hired a communications professional to provide communications support for its programs and services.

APRA will also continue to monitor the sale of tobacco to minors through the Synar compliance program, to ensure that the rate of non-compliance does not rise above the FY2001 rate of 15 percent. In addition, it will broaden vendor education activities to include the prohibition of sales of alcoholic beverages to people under the age of 21. APRA will also help educate community groups fighting new liquor establishments in "saturated" neighborhoods and will assess existing laws to improve legal age verification in nightclubs and bars.

The Alcoholic Beverage Regulation Administration (ABRA), responsible for the administration and enforcement of the ABRA laws and regulations related to the importation, distribution and sale of alcoholic beverages in the District, takes action against locations selling alcohol to minors. ABRA will communicate with the appropriate Working Groups to identify and adopt national best practices aimed at reducing underage drinking.

Increase the effectiveness of the District's prevention workforce by training youth development and prevention professionals to implement effective prevention strategies.

APRA provides the requisite 100 hours of alcohol, tobacco, and other drug prevention training to staff and grantee organizations. In addition, APRA will fund a week-long prevention institute that will train 50 to 60 people on effective prevention programming, community capacity building, sustainability, and the integration of prevention education within other programming, such as sports and the arts. APRA will also sponsor a series of workshops on key prevention strategies across the continuum of care.

Additionally, the District's interest in peer-to-peer programming is fueled by positive experiences among private sector programs and the opportunity to validate peer programs for District youth. The DC Department of Health and partnering agencies will contract to provide training of teenagers as substance abuse peer counselors in school and communities.

REDUCING THE DISTRICT'S ADDICTED POPULATION

Goal 2: Develop and maintain a continuum of care that is efficient, effective, and accessible to individuals needing substance abuse treatment.

The Treatment Working Group proposed objectives to achieve the target of reducing the number of individuals addicted to substances by 25,000 by 2010. Many of their ideas focused on resources to increase treatment availability, but there was also a keen interest in infrastructure matters. In this regard, the treatment Working Group identified the need for the District's treatment providers to become part of a comprehensive, coordinated treatment system. Many of the treatment providers had never before met collectively to discuss treatment problems and needs and expressed a strong desire to convene an annual treatment summit to discuss system needs and the latest scientific advancements in treatment. They expressed an interest in meeting regularly to improve coordination and collaboration to enable the District to achieve its target of reducing the number of addicts by 25,000.

Currently, the majority of the District's public treatment services are provided by agencies with which APRA has "fee-for-service" agreements. The remainder are administered by APRA directly. The treatment Working Group concluded, with APRA concurrence, that for APRA to act as a true single state agency (SSA) (the federally recognized authority for coordinating alcohol and other drug abuse programming and services for a state), APRA must stop providing direct services. APRA is making great strides in this area, thereby enhancing its much-needed broader role in developing and managing the treatment *system* rather than managing individual treatment programs.

To advance implementation of efficient and effective treatment services, APRA's Office of Special Population Services (OSPS) will review and comment on all APRA treatment efforts before solicitation, award and implementation. This will ensure that funding supports services that are responsive and accessible to the profile of the District's substance abuse population by addressing ethnic, cultural, language, age, sexual orientation (gay, lesbian, bisexual and transgender) diversity. Additionally, OSPS will ensure that APRA-funded treatment efforts integrate early medical intervention for sexually transmitted disease and other co-occurring diseases. OSPS will also provide ongoing technical assistance and monitoring of APRA's treatment efforts to support continued assurance of service responsiveness to diversity and co-existing disorders including, but not limited to, mental illness, HIV and other infectious diseases.

Objectives:

Increase long-term treatment capacity, especially for youth and women with children.

It is essential that additional treatment capacity become available to enable more District residents to receive treatment. However, APRA's budget has been reduced over the last two years and the DC inspector general in a 2003 report identified, among several other factors, a lack of resources as a major impediment to APRA reaching this goal. The Choice in Drug Treatment Act, passed by the Council of the District of Columbia in FY 2000 had a significant impact on this "treatment gap." The legislation directed APRA to establish a voucher system for treatment, which was implemented on Oct. 1, 2002. Treatment services are now funded on a fee-for-service basis. Although enhancing treatment options, the fee-for-service payment structure often results in a faster depletion of treatment resources because a higher percentage of clients can now choose longer-term, higher-cost residential treatment programs. In addition, APRA must place patients only with providers who have met certification requirements. To date, 23 service providers have been fully or provisionally certified to participate in the Drug Treatment Choice Program.

The success in implementing the Choice in Drug Treatment Act is noteworthy in that certification is a prerequisite for the District to gain Medicaid reimbursement for treatment services provided to Medicaid-eligible clients. With the approval of the Medicaid Rehab Option for Substance Abuse Services, expected in 2003, the District will gain access to much-needed additional revenues. (Two million to 3 million dollars annually in new funds will be realized from billing for services provided to the 20 percent to 30 percent of APRA's total client base that is Medicaid eligible.) In addition, APRA's continual improvement of the Drug Treatment Choice program will place the District in an excellent position to receive funds from the federal government's new treatment voucher program, which is proposed to begin in FY 2004.

In light of these current budget realities, APRA will expand its efforts to lead the District's public health and criminal justice communities' wide range of providers (e.g., clergy, emergency room doctors, judges, attorneys, and employers) to increase their outreach to addicts through "brief interventions." This has been shown to be a powerful way to intervene at a very low cost. Not every individual requires formal treatment to recover. APRA will encourage stricter triage and assignment of clients to appropriate support, including referral to mutual support programs (e.g., Alcoholics Anonymous and Narcotics Anonymous).

The District is also working toward increasing treatment capacity for special populations as follows:

Youth. APRA met a Treatment Choice Act mandate to increase adolescent substance abuse treatment slots with a $2 million set-aside that has doubled adolescent slots from 81 to 160. By the end of December 2003, APRA plans to have an additional 164 treatment slots—creating the capacity to treat 325 adolescents per year. Among a number of other activities APRA is conducting to obtain additional treatment resources, APRA entered into a memorandum of understanding (MOU) with the Youth Services Administration on a grant application to provide treatment services for youth re-entry services. To build a needed continuum of youth treatment services, APRA is contracting for outpatient, detoxification/acute care and residential services.

Homeless and Mental Health. Two populations being targeted for increased treatment capacity are homeless people and individuals with co-occurring disorders. Many homeless individuals have either a substance abuse problem, a mental health disorder, or co-occurring mental health and substance abuse problems. There are many individuals who are not homeless, but who are at risk for homelessness or incarceration because they

have co-occurring substance abuse and mental health disorders.

The Department of Mental Health (DMH) and APRA, informed by a charter signed by the mayor in April 2003, are joining together to help individuals with co-occurring disorders through the implementation of an initiative based on the Comprehensive, Continuous, Integrated System of Care model. This has created new service responses including a program for homeless individuals during hypothermia season and expanded outreach and assessment activities to identify appropriate, long-term treatment and support services for these two populations. In addition, APRA and the Community Partnership for the Prevention of Homelessness will coordinate and cooperate to serve homeless individuals with substance abuse problems. These groups will also work with the Department of Human Services to strategically bring their treatment systems together.

Criminal Justice. With regard to probationers and parolees, the Court Services and Offender Supervision Agency (CSOSA) was established within the executive branch of the federal government by the National Capital Revitalization and Self-Government Improvement Act of 1997 to manage substance abuse treatment services to people in the criminal justice system. CSOSA placed 1,344 offenders in contract treatment in FY 2001. Pre-Trial Services Administration, an independent entity within CSOSA, has the capacity to provide treatment to 1,500 defendants. Although APRA partners with CSOSA to ensure the availability of treatment slots for the criminal justice population, no funding for treatment is provided directly to APRA by CSOSA. CSOSA's direct appropriation from the U.S. Congress for substance abuse treatment services substantially reduces the District's direct financial burden associated with providing treatment to District adults in the criminal justice system. APRA will continue to provide medical detoxification and residential treatment for clients unable to be served by CSOSA, methadone treatment, juvenile detoxification, outpatient abstinence services, and in-take assessments. APRA and CSOSA will continue to coordinate their efforts to ensure that this critical population receives rehabilitation and re-entry services.

Increase the management effectiveness and efficiency of APRA.

To better serve the addicted population with limited resources and to address any deficiencies in APRA's operations, APRA will conduct a thorough assessment of its management practices. To focus these efforts the D.C. Department of Health Director James A. Buford instructed APRA staff in June 2003 to develop a 100-day action plan. The plan, spurred by APRA's goal to transition itself into an effective single state agency, includes the following:

Goal: Achieve full single state agency capability

Objectives:

*Outsource 80 percent of APRA-operated treatment programs.

*Enhance capacity of provider agencies to meet established standards of care under certification requirements.

Goal: Enforce management/operational accountability

Objective:

*Conduct detailed operational review of each major cost component and program activity to identify operating inefficiencies and cost savings for expanding capacity.

Goal: Increase treatment capacity

Objective:

*Identify and evaluate options to grow treatment capacity.

Goal: Improve program efficacy

Objectives:

*Develop and implement evidence-based programs and practices.

*Complete clinical and program assessment of Detoxification and Central Intake.

*Complete employee skills assessment and performance reviews to determine specific training and job development requirements.

Some APRA management issues identified as objectives above are further highlighted as follows:

APRA is currently reviewing the management of its central detoxification facility to ensure that individuals in need of drug treatment are not denied treatment due to insufficient capacity, excessive waiting times, or ineffective processing. It has also requested additional funding for the modernization of its detoxification facility. APRA has hired additional culturally competent bilingual staff to ensure that the needs of the addicted non-English speaking population are met. APRA is also working to increase outreach and transportation for hard-to-reach populations to access detoxification services and the continuum of care.

APRA will continue to enforce compliance with certification standards for all District of Columbia substance abuse treatment programs. This task is not as simple as it sounds. Treatment is a complex and varied network of services tailored to meet the particular needs of an individual. Treatment takes place in hospitals or in long-term residential settings, walk-in clinics, and outpatient counseling centers, and the type of treatment provided will depend on the client's drug use history, previous treatment, social needs, criminal record, economic status, and personality attributes. Having developed standards for treatment, APRA ensures that services offer quality and consistency across programs while maintaining flexibility to meet a client's particular needs.

In the climate of managed care, it is important to define standards that are the basis of licensure of programs. However, meeting such standards should not be an undue burden. APRA will streamline existing standards as well as the certification process to ensure a safe environment for recovery as well as sufficient treatment capacity.

Improve the treatment infrastructure by providing staff development through technical assistance and training.

The expansion of treatment capacity is not enough in and of itself to guarantee results. The expansion of capacity must be accompanied by training, technical assistance, and other means, such as program certification to build and maintain competencies among treatment providers. Training and technical assistance can help to ensure that every service is efficiently and effectively provided. To meet this growing need, the District will assist providers to expand their use of national programs that offer technical assistance and training, such as the Substance Abuse and Mental Health Services Administration's Addiction Technology Transfer Centers.

In addition, APRA will form a committee to review pay scales and provide recommendations on how to attract and retain qualified treatment professionals. The treatment provider community is greatly concerned about its ability to attract and retain professional staff trained in the provision of treatment services. The treatment Working Group noted that pay scales are the source of high turnover rates. Personnel are being lost to higher paying private programs, other social service programs, and to substance abuse treatment programs outside the District. This human resource outflow suggests that public treatment programs in the District are attracting mostly entry-level professionals. This staffing weakness undermines quality improvement in treatment programs because programs tend to lose experienced staff. The

treatment stakeholder Working Group could not quantify the extent of this problem, however. It is essential that the District research its nature and extent.

Develop an accessible, integrated continuum of care containing all the necessary components, including aftercare, for individuals needing substance abuse treatment.

The Working Groups will review the District's current aftercare capacity to ensure that individuals who receive treatment continue to receive necessary follow-up services. APRA and DMH are also developing a case management system to provide a coordinated approach to the delivery of substance abuse treatment in the District. This system will provide a single point of contact for multiple health and social services to assist clients over the entire treatment continuum.

In the area of methadone treatment, there is no continuum in place to transition patients out of methadone and into recovery, i.e., APRA does not have a "step-down" plan to move its methadone clients off of methadone when appropriate. APRA will investigate shifting individuals from methadone treatment to other treatments and necessary aftercare which, in turn, will free up methadone treatment slots.

Develop a District-wide performance accountability system for treatment programs to support continuous quality improvement.

A substantial body of national research has demonstrated treatment's effectiveness using a core set of outcome measures. One prominent national study, the National Treatment Improvement Evaluation Study (NTIES), a five-year congressionally mandated study from 1992 to 1997, used outcome measures in four areas (drug use, crime, employment, and homelessness) as the basis for measuring treatment program performance. It found that treatment was effective in these areas 12 months following treatment:

- Illicit drug use dropped an average of 50 percent;
- Crime as measured by assault and batteries dropped by 78 percent, drug selling by 78 percent, shoplifting by 82 percent, and arrests by 64 percent;
- Homelessness dropped by 43 percent and receipt of welfare income by 11 percent; and
- Employment increased 19 percent.

Continued progress in achieving these positive treatment outcomes requires that programs be held accountable through a performance measurement system. APRA will take the lead to introduce performance accountability in the District. APRA will work with treatment providers to implement a performance measurement system that strengthens program performance and gives treatment providers, policy and program managers, and the public a better understanding of the effectiveness of treatment and mechanisms for its improvement.

A three-year, $3 million project will greatly aid APRA's efforts to move this endeavor forward. APRA's FY 2004 capital budget requests $1 million for automating APRA's patient record system. (Funding is proposed to be continued at that level for the next two fiscal years.) This project will expand upon the federal government's Veterans Administration Computerized Patient Record System that DOH is currently implementing. This project involves expanding an automated patient record system to APRA's Central Intake and Detoxification units, thus creating the infrastructure needed to extend an automated patient record system to community-based providers.

As mentioned earlier, APRA and DMH are also developing an additional management information system to track clients and their involvement with social service providers. The intent is to make APRA and DMH the single point of entry for all clients to ensure

the best and most appropriate placement of individuals into treatment.

REDUCING DRUG-RELATED CRIME

Goal 3: Increase the public's safety and improve treatment access for offenders to ensure fair and effective administration of justice in the District.

The District's Criminal Justice Coordinating Council (CJCC) met to review specific objectives for the criminal justice goal. The criminal justice system has become one of the largest sources of referral to treatment. The CJCC identified a number of problems. One is the lack of a central criminal justice information repository to manage clients who are in need of treatment. This information gap applies to both adults and juveniles. Another problem centered on the lack of sufficient treatment capacity that was addressed in the previous discussion of treatment goal action items.

Objectives:

Reduce the number of open-air drug markets.

Open-air drug markets create disorder and fear in DC neighborhoods. A survey of residents conducted during the summer of 1998 found that, among major crimes, "street drug dealing" ranked first in five of the seven police districts as a "big problem" in city neighborhoods. According to "Facing Facts: Drugs and the Future of Washington, DC," a report published in 1999, more than half of adult Washingtonians have seen or heard about drugs being sold in their respective neighborhoods. The Metropolitan Police Department's (MPD's) anti-drug plan focuses on neighborhoods and recognizes that some neighborhoods suffer from the illegal drug trade more than others.

The linchpin of the focused law enforcement effort is the undercover Narcotics Strike Force (NSF). NSF moves from one hot spot of violence and drug dealing to another, working with the District personnel to disrupt the market by arresting the dealers and deterring buyers from entering the area. After the NSF moves on to another hot spot the Mobile Force--District-focused mission teams--and Police Service Area (PSA) officers continue to saturate the location with uniformed presence to keep the market from starting up again. The NSF began operating in October 2000. In fiscal year 2001, the NSF arrested nearly 2,000 suspects on narcotics-related charges, with more than half of the cases involving felonies and with a high papering rate of 90 percent. The NSF also seized more than $320,000 in cash, 80 weapons and 50 vehicles during this period. Perhaps most importantly, drug-related calls for service declined in specific neighborhoods, indicating that the targeted NSF approach is having a long-term impact as well.

In fiscal year 2003, the NSF has worked with the Homicide Investigation Unit to gain information on homicides and reduce the violence associated with drug dealing. The NSF has focused on police service areas (PSAs) with the highest level of violence. In these PSAs, buy/bust operations, surveillance, and other operations are used to identify and arrest the major players contributing to drug dealing and violence.

The MPD has also begun using the Anti-Loitering/Drug Free Zone law. This law, among other things, provides that the chief of police may declare any public area a drug free zone for a period not to exceed 120 consecutive hours. The factors that the chief of police will consider in declaring a drug free zone include the number of arrests for the possession or distribution of illegal drugs, number of homicides related to possession or distribution of drugs, evidence that shows that illegal drugs are being sold and distributed on the public space, and any other verifiable information that the chief of police may ascertain that threatens the health or safety of people living in the area.

There are at least two drug free zones declared every week by the chief of police. Based on a limited review of the information, drug dealing is severely curtailed during the time that a drug free zone is declared.

Form community-police partnerships to enhance neighborhood problem solving.

Many residents of beleaguered neighborhoods are fearful for their physical safety and do not confront the drug dealers who may be using their property. This creates a social environment that appears to tolerate alcohol and drug use and permit open-air drug dealing. The problem is exacerbated by poor physical conditions (e.g., vacant buildings, abandoned autos, trash, graffiti, and poor lighting) that attract and conceal drug dealing. Especially in neighborhoods where the problem has become completely entrenched, residents do not trust the police to protect them from the retribution of drug dealers. Yet cooperation between police and residents is necessary for reclaiming the neighborhood and sustaining success.

Focused law enforcement, such as the NSF and the drug free zones are just first steps in MPD's comprehensive neighborhood-based anti-drug plan. They establish at least a temporary reprieve from the drugs and violence, and help build trust among residents for the second essential step—a neighborhood partnership approach that builds a problem-solving collaborative among police, community, and other agencies. In 2002, the MPD launched the Capital Community Partnership Project (CCPP) to continue the transition of six targeted open-air drug markets into first-rate Capital Communities. The project was originally designed to broaden community involvement, build community capacity, and initiate long-term prevention efforts in each of the six areas. Since its inception, the geographic focus of the project has broadened and it has been renamed as simply the Community Partnership Project. In addition, in 2003 the Community Partnership Project is working closely with Neighborhood Services to facilitate collaboration among community residents, community-based organizations, police officers, and other agencies. The cooperative effort will also support training and technical assistance and document best practices.

In addition, MPD is the lead agency in Operation Fight Back. Operation Fight Back uses the agencies participating in the Neighborhood Services Core Teams to address the physical disorder in neighborhoods plagued by crime.

Strengthen the ability of law enforcement to anticipate and respond to drug-related crime.

The MPD's Policing for Prevention program consists of three approaches—focused law enforcement, neighborhood partnerships, and systemic prevention. The last approach consists of the police working with other government services, churches, and social services, to help individuals, families, and communities build a resistance to crime and violence. Interventions address the health, social, educational, and economic conditions of people and their environment. The systemic prevention approach is necessary because law enforcement efforts, and even community policing efforts, are not sufficient to solve crime problems that emerge from the entrenched social and economic poverty in many communities.

One of the MPD's systemic prevention efforts is overseen by the Office of Youth Violence Prevention, which was established in 2000 to work with high-risk youth. The target population is young people between the ages of 14 and 24, who are in danger of being a victim or the perpetrator of violence—often drug-related violence. The Youth Violence Intervention Team works with parole and probation agencies to target these high-risk youth for joint supervision and social services, such as job skills, education, and counseling. The Youth Violence Prevention Office has also sponsored citywide athletic activities, life skill classes, and other activities for these high-risk youth. The office works in conjunction with schools, clergy, and

grassroots groups, such as the Community Partnership and the Alliance of Concerned Black Men, that are dedicated to keeping young people away from gangs and drugs, with the ultimate aim of reducing youth violence.

A recent example of this type of work was the establishment of the Gang Intervention Partnership in Columbia Heights. The MPD, U.S. Attorney's Office, Corporation Counsel, CSOSA, schools, and community-based organizations joined together to intervene and stop gang violence in Columbia Heights. The goals of this partnership include arrest and prosecution of violent offenders, mediation and conflict resolution, and sharing of information. This approach represents the best of "policing for prevention" in action.

Support the expansion of drug courts.

Many adults and children entering into the child welfare and criminal justice systems are users and abusers of alcohol and other drugs. The effects can impair parenting skills and threaten the safety of children in our community. Research has demonstrated that substance abuse is never a stand-alone issue, but rather is linked with delinquency, family violence, welfare reform, and mental health.

Drug courts are an effective, accountable mechanism to simultaneously address many of these issues. The CJCC's Substance Abuse and Mental Health Workgroup will work to identify national best practices for potential replication in the District. Special attention will be given to the research on effectiveness of criminal justice oversight through the implementation of drug courts in addressing treatment access, referral and service delivery. According to the CJCC there is a great need for expansion of these courts, and its exploration of best practices will support the expansion of effective drug courts in DC.

An example of a drug court is the family drug court, which is a court that has jurisdiction over a family unit. It involves a collaborative effort in which the court and practitioners of treatment and child welfare work together to conduct comprehensive needs assessments and build workable case plans that give clients a viable chance to achieve sobriety, become responsible adults, and hold families together. The family drug court represents a shift in court thinking to effectively address the needs of families to ensure the safety and well being of the children and family unit as a whole.

Through a partnership between the Office of the Deputy Mayor for Children, Youth, Families, and Elders and the Family Court, APRA is collaborating with the Child and Family Services Agency (CFSA), the Departments of Mental Health and Human Services, and other critical stakeholders to support the implementation of the new Family Treatment Court based on best practices. This one-year pilot program began in May 2003 to provide services to 36 women and their families. To implement the pilot, CFSA and APRA signed an MOU that transfers $1.4 million from CFSA to APRA to ensure that appropriate treatment and aftercare capacity is available for these families.

Improve case management of defendants/offenders and their transition back into the community, including re-entry support services.

A truly effective and fair criminal justice system requires comprehensive case management. Effective case management, in turn, requires intra- and interagency collaborative case management techniques to facilitate problem-solving and assure that comprehensive client services are provided.

Currently, there is no single information system available to criminal justice stakeholders in the District. In addition, there is no clearinghouse of available treatment programs or data-tracking system to capture treatment outcomes.

A working subgroup has been established by the CJCC to devise a plan for such an information management system. The working subgroup will focus on how the system should be established and

implemented, and the costs associated with District-wide implementation. This working subgroup will report to the Task Force on its progress and will make recommendations on how best to implement the system, at what cost, and over what time period. APRA will coordinate with this working group to ensure that the information systems that are developed for the criminal justice system and APRA clients are coordinated where necessary and appropriate.

Develop law enforcement and prosecutorial opportunities to divert non-violent youth to alternative community-based interventions.

Juvenile delinquency is one of the nation's and the District's most threatening social problems. Many of the cases involving youth in the criminal justice system are directly related to substance abuse issues. The lack of community-based services and opportunities for youth, particularly the lack of substance abuse treatment services for youth, has been cited as a major barrier to addressing youth violence and substance abuse issues.

Establishing adolescent prevention and treatment alternatives as diversion opportunities for youth, as well as educational and recreational support services, will serve to deter further involvement in the juvenile justice system and decrease the recidivism rate of youth entering into the system. APRA will partner with DMH to create alternatives that can best serve non-violent youth with substance abuse problems.

IMPROVING COORDINATION IN THE GREATER METROPOLITAN AREA

Goal 4: Encourage a coordinated and focused regional response to the problem of substance abuse.

The District recognizes that the drug-related activities of the federal and other adjacent governments are inextricably linked to those of its own. To avoid working at cross-purposes, substance abuse policymakers throughout the region must make every effort to coordinate and cooperate as they develop and enforce policies and laws. The Washington, DC, area includes 17 local governments surrounding the nation's capital as well as Maryland and Virginia legislatures, the U.S. Senate and the U.S. House of Representatives. The District will work closely with regional planning groups, such as the Metropolitan Washington Council of Governments (COG), in an effort to develop a sound regional response to the issue of substance abuse.

Objectives:

Promote regional resource sharing and opportunities for joint initiatives through partnerships among federal, state, county, and District drug control agencies.

The District will work closely with federal agencies as well as with COG in the following three areas to provide a focus for the sharing of resources, programming, and information:

- *Target substance abuse-related crime and violence across the region through law enforcement partnerships across jurisdictions.*

The District will coordinate with COG's Public Safety Committee that includes every police chief in the region. They will propose possible collaborative efforts to address substance abuse-related crime and violence, including open-air drug markets and drug use on college and university campuses throughout the area.

- *Encourage the implementation of science-based prevention and treatment practices throughout the region.*

The District will work with both the Substance Abuse and Mental Health Services Administration and COG's Prevention and Treatment Subcommittees to host a Best Prevention and Treatment Practices conference. The conference mission will be to disseminate best practices to behavioral health

professionals, program providers, and policymakers throughout the Washington area.

- *Facilitate the ongoing collection and dissemination of regional drug use data, including youth alcohol, drug, and tobacco use.*

Strategy stakeholders throughout the region expressed a need for current information on drug use from a metropolitan-area perspective. Such information would assist in the detection of emerging drug trends and the determination of needs. The District will work with the federal government's Office of National Drug Control Policy and COG to discuss the development and implementation of a drug use "pulse check" survey for the metropolitan Washington area.

Foster the adoption of consistent and mutually supportive anti-substance abuse laws and policies across jurisdictions.

The District will work in partnership with local organizations, both non-profit and university based, to study the similarities and differences among anti-substance abuse laws across the region. Anti-substance abuse laws and policies will be recorded and analyzed across city, county, state, and college campus boundaries to determine what changes and adjustments are required to produce a region–wide united front against substance abuse. Particular attention will be paid to laws and policies designed to restrict the use of alcohol and tobacco by youth. APRA will report the findings of its partnership effort, including recommendations for legislative action, to the Task Force within nine months.

Identify and remove barriers to treatment across jurisdictions.

Treatment referrals are impeded for a variety of reasons throughout the region. In some cases, medical personnel are simply not aware of the resources and programs that are available to treat substance abusers, including those with co-occurring disorders. Eligibility for programs can depend on age, place of residence, third-party payment options, involvement with the criminal justice system, health status, and a range of other factors.

The CJCC and APRA will work with regional planning groups, including COG's Substance Abuse Treatment Committee, to identify and resolve specific barriers to treatment access, referral, and service delivery.

Two populations that can benefit the most from being aware of treatment options and how to access them are criminal justice personnel and those working in area hospitals, emergency clinics, and outpatient settings. Accordingly, the CJCC will work with Washington area planning groups to host a regional conference during 2004 to:

- *Educate judges, probation officers and other criminal justice personnel about treatment referral and treatment options; and*
- *Educate medical providers throughout the area about treatment referral and treatment options.*

TRACKING PERFORMANCE

The Task Force, at the mayor's request, has determined performance measures by which to track the Strategy's progress toward the achievement of three results by 2010. The first result is the reduction in the number of individuals addicted to drugs and alcohol by 25,000 from an estimated baseline of 60,000. The second result is a reduction in social costs by $300 million from an estimated baseline of $1.2 billion. And the third desirable result is a reduction in youth drug use measured by two variables: changes in prevalence (reductions by an amount for certain categories of drugs and alcohol) and incidence (reductions in first-time use).

Estimating Social Cost of Substance Abuse: At this time, the District does not have a means to estimate changes in the social costs of substance abuse. The estimate of social costs in the District of Columbia of $1.2 billion used in this Strategy was estimated by Drug Strategies, which extrapolated it from a 1995 national estimate of social costs. For purposes of performance measurement, the

District needs to develop an independent, valid methodology.

The Task Force directs APRA, with support from other District Agencies, to take the lead for developing a biennial estimate of social costs in the District and to report biennially to it for purposes of tracking the Strategy's progress. The first social cost estimate is due in spring 2005.

Counting the Number of Addicted Individuals: The Task Force estimates that approximately 60,000 District residents are addicted to alcohol and other drugs and has established the performance goal of reducing this number by 25,000 by 2010. The estimate of 60,000 is based in part on the 2000 DC Household Survey on Substance Abuse (Household Survey), which reports nearly 40,000 individuals addicted to alcohol and drugs. The Household Survey undercounts addicts because it excludes places such as treatment facilities, shelters, college dormitories, nursing and assisted living facilities, and does not sample the homeless. Methodologies exist that provide population-based (rather than household-based) estimates of the addict population.

The Task Force directs APRA, with support from other District agencies, to develop recommendations on how to improve estimates of the number of individuals addicted to substances. APRA should consider alternative methodologies and develop cost estimates for each for consideration by the Task Force. The new estimate of the number of addicts is expected in spring 2005.

Monitoring Youth Drug Use: This Strategy has identified youth drug, alcohol, and tobacco use as policy targets for 2010. Two areas are proposed for each of these drug categories: reductions in first-time use (initiation) and prevalence (30-day or past month use). The Task Force believes that by monitoring the 12 to 17 age cohort through the DC Household Survey the District will acquire the information it requires to determine the success of its programs targeting youth. The Task Force directs APRA, with support from other District Agencies, to develop recommendations by fall 2003 on how the District may conduct biennial surveys of drug use. These recommendations are to include estimates of the cost of conducting the survey. The first estimate is planned for fall 2004.

Chapter 6

CONCLUSION

THE ROAD AHEAD

Long-term efforts to tackle the problems of substance abuse and drug dealing have greatly improved the health and safety of District residents. Although progress has been real and significant, particularly with regard to reductions in drug-related crime and illness, there have been some set backs, including a resurgence in the homicide rate. Moreover, District residents have only begun to benefit from the investment in reducing substance abuse and its consequences. Progress that has occurred to date must be seen for what it is: an initial payoff from an initial investment. The District has completed the first two phases of its substance abuse-related strategic planning process (see Figure 1). More must be done and the Task Force members are committed to seeing that it is.

During the months ahead, the Mayor's Interagency Task Force on Substance Abuse Prevention, Treatment and Control (the Task Force) will continue to push for a larger investment and sustained commitment to address substance abuse and its damaging effects on young people and the entire community. With both leadership and a "venture capital" outlook on substance abuse funding, District residents will ultimately be rewarded with safer streets, healthier children, stronger families, and a better environment within which to live, work, and prosper.

The formulation of this citywide Substance Abuse Strategy (the Strategy) has achieved a number of notable firsts in the District's substance abuse policy history. For the first time, the District has a reliable assessment of the nature and extent of the drug problem affecting its population. For the first time, the city has a set of articulated goals and objectives to achieve progress and lasting results. For the first time, the District has a comprehensive plan of action that includes all dimensions of the local area drug market, from drug use to drug dealing. For the first time, the District has identified performance targets against which to provide feedback about its progress in achieving results. And for the first time, the District has an oversight body to monitor implementation and to ensure accountability for results.

This Strategy could not have been produced without the extensive involvement of the stakeholder community. The Strategy Working Groups, formed by the Task Force and comprising representatives of the prevention, treatment and criminal justice communities, as well as the Neighborhood Forums, identified key issues and specific ideas that they believed could lead to improvements in the substance abuse problem in the District. In many instances, the Working Groups brought together individuals and organizations for the first time to discuss the substance abuse problem in the District. Many treatment providers, for example, had never sat down together with District officials to discuss the problems they faced in providing services to the city's addicted population.

As the Strategy Working Groups continued to meet and expand over time, a range of community assistance organizations as well as representatives from the District's early childhood development community, and the Criminal Justice Coordinating Council provided valuable guidance to the strategic planning process. Moreover, the Metropolitan Washington Council of Governments offered tremendous perspective on the substance abuse problem affecting the greater metropolitan region and generated useful ideas for further study and ways to improve

regional coordination. In the months to come, the Task Force will continue to rely on these Working Groups, as well as neighborhood coalitions, collaboratives, and other grassroots organizations, for input and advice.

This Strategy is a dynamic plan that requires continuous monitoring and oversight. The mayor intends to rely on the Task Force to manage and oversee substance abuse control efforts in the District and to report on the District's progress toward achieving results. Over the next year, it will engage a number of activities to track the government's efforts in reducing demand and drug trafficking. Its efforts and responsibilities will include the following:

- **Annual Report to the District:** The Task Force will prepare an annual report to the District on its progress in achieving results and biennially discuss those results as defined by the performance outcomes.

- **Program Inventory and Budget Review:** The Task Force will prepare annually a consolidated substance abuse program inventory and budget describing government activities and expenditures in the District, including local and federal expenditures. The Task Force will work with the city administrator to help coordinate the mayor's budget priorities for substance abuse.

- **Action Plans:** The Task Force will convene regular meetings of the prevention, treatment, criminal justice, and regional Working Groups, with continuing stakeholder input, to build action plans for each objective by logically outlining what activities and outputs should occur, by whom, and by when. Through this process District agencies and other working group participants will improve coordination of existing activities and identify and collectively address gaps in the system. These plans will be used by the Task Force as a means for holding individual agencies accountable for their responsibilities.

- **Data Analysis:** The Task Force will coordinate the biennial collection of drug-related data to illuminate the nature and extent of drug use and trafficking in the District. It will oversee the collection of local data, such as the DC Household Survey on Substance Abuse, and will coordinate with national organizations, such as the Substance Abuse and Mental Health Administration and the National Drug Intelligence Center, for assistance in data collection. The Task Force will include a discussion of the drug problem in its annual report to the District.

- **Coordination:** The Task Force will ensure that the activities of the Strategy are well coordinated with existing District agency strategic plans through a regular "crosswalk check" of Strategy action items and agency programming.

These activities will strengthen the District's planning, monitoring, and oversight of the Substance Abuse Strategy. They will craft solutions, in a methodical and measurable manner, for critical problems that have faced the District for the last decade. Perhaps most important, they will address the gap between treatment services and the numbers of addicts who could benefit from them and the disturbing lack of treatment options for drug-involved youth and addicted women with children.

Although many government-generated reports are quickly forgotten, the Task Force, according to the mayor's order, will report regularly on the District's progress toward achieving results and continue to consult with the stakeholders to whom it is accountable and who stand to gain the most by the Strategy's advances and outcomes.

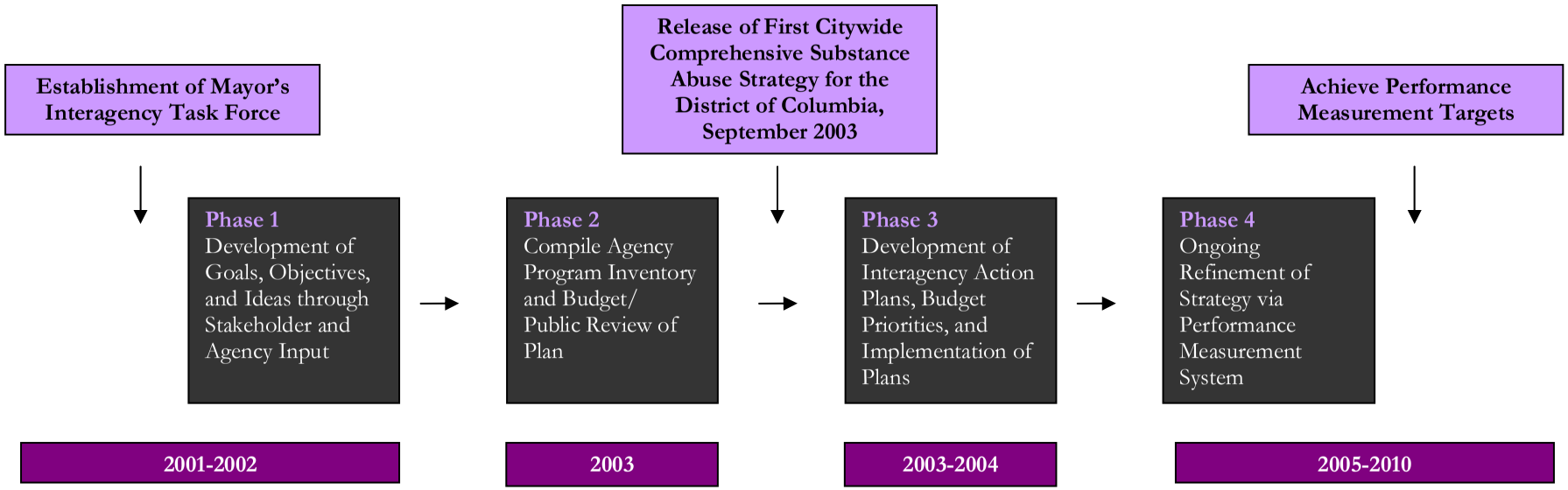


Figure 1
Timeline for Strategy Development and Implementation

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Appendix A

SUBSTANCE ABUSE-RELATED DATA FOR THE DISTRICT OF COLUMBIA

Up-to-date information on the availability and prevalence of illegal drugs is vital to the understanding and implementation of a drug strategy. The health, criminal, and social implications of drug abuse also play an important role in a comprehensive drug strategy. The following tables provide an extensive overview of the drug problems facing the district as a whole, as well as the specific issues affecting each ward. These tables provide a basis to assess the current level of drug abuse, the availability of drugs, the impact of drug abuse, and the availability of treatment in the District of Columbia.

LIST OF TABLES

Table A-1
Alcohol Consumption
(gallons of pure alcohol per capita)

	1991	1992	1993	1994	1995	1996	1997	1998	1999
Beer									
D.C.	1.44	1.64	1.56	1.56	1.56	1.49	1.50	1.47	1.48
U.S.	1.29	1.29	1.28	1.26	1.25	1.25	1.24	1.25	1.25
Wine									
D.C.	0.62	0.72	0.75	0.76	0.74	.77	.79	.79	0.79
U.S.	0.30	0.30	0.29	0.29	0.29	.30	.31	.31	0.32
Spirits									
D.C.	1.87	1.77	1.58	1.57	1.58	1.54	1.72	1.55	1.47
U.S.	0.71	0.71	0.68	0.66	0.64	.64	.63	.63	0.64
All Alcoholic Beverages									
D.C.	3.93	4.13	3.89	3.89	3.89	3.80	4.01	3.81	3.74
U.S.	2.30	2.31	2.25	2.21	2.17	2.19	2.18	2.19	2.21

Source: National Institute on Alcohol Abuse and Alcoholism, Surveillance Report #59, September 2002

Table A-2
Alcohol Outlets

	D.C.	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Ward 7	Ward 8
Total Number of Licensed Outlets	**1,556**	264	609	153	103	137	206	43	41
Restaurants and Taverns	**890**	142	484	110	30	24	95	4	1
Percentage	**57%**	54%	79%	72%	29%	18%	46%	9%	2%
Liquor and Convenience Stores	**666**	122	125	43	73	113	111	39	40
Percentage	**43%**	46%	21%	28%	71%	82%	54%	91%	98%

Note: "Restaurants and Taverns" also includes hotels, nightclubs and private clubs.
Source: D.C. Department of Consumer and Regulatory Affairs, 1998

Table A-3
Percentage Reporting Alcohol Use, Total, By Age Group

Age Group	Lifetime	Past Year	Past Month
		Percentage	
12-17	34.1%	28.8%	17.2%
18-24	84.5%	76.5%	64.8%
25-34	83.6%	75.3%	59.5%
35+	83.0%	55.1%	47.5%
Total	**80.3%**	**60.1%**	**50.1%**

Source: District of Columbia, Department of Health, Addiction Prevention and Recovery Administration, 2000 Household Survey on Substance Abuse: Main Findings, September 2001.

Table A-4
Percentage Reporting Alcohol Use, Total, by Ward

Ward	Lifetime	Past Year	Past Month
1	82.9%	58.9%	51.7%
2	90.1%	76.2%	73.8%
3	98.5%	84.6%	76.8%
4	51.3%	35.9%	20.5%
5	84.0%	55.7%	42.8%
6	83.4%	58.8%	46.4%
7	70.9%	51.2%	38.8%
8	77.1%	53.0%	41.3%
Total	**80.3%**	**60.1%**	**50.1%**

Source: District of Columbia, Department of Health, Addiction Prevention and Recovery Administration, 2000 Household Survey on Substance Abuse: Main Findings, September 2001.

Table A-5
Percentage Reporting Cigarette Use, Total and by Age Group

Age Group	Lifetime	Past Year	Past Month
Total	**70.6%**	**29.6%**	**25.7%**
12-17	26.1%	19.4%	12.1%
18-24	64.2%	39.2%	31.8%
25-34	70.4%	33.1%	25.6%
35+	76.2%	27.6%	25.9%

Source: District of Columbia, Department of Health, Addiction Prevention and Recovery Administration, 2000 Household Survey on Substance Abuse: Main Findings, September 2001.

Table A-6
Percentage Reporting Cigarette Use by Ward

Age Group	Lifetime	Past Year	Past Month
Ward			
1	76.2%	29.5%	28.0%
2	77.1%	29.1%	25.8%
3	88.7%	20.2%	11.7%
4	39.4%	9.4%	7.8%
5	73.0%	32.5%	30.5%
6	80.3%	37.2%	30.1%
7	62.0%	39.4%	35.5%
8	66.0%	45.5%	41.8%

Source: District of Columbia, Department of Health, Addiction Prevention and Recovery Administration, 2000 Household Survey on Substance Abuse: Main Findings, September 2001.

Table A-7

Percentage Reporting Past Month Use of Any Illicit Drugs by Gender and Other Characteristics

	DC	National
Total	**9.6%**	**6.3%**
Gender		
Male	14.0%	7.7%
Female	5.8%	5.0%
Race		
White	6.6%	6.4%
Black	11.5%	6.4%
Hispanic	7.3%	5.3%
Other	7.8%	NA
Education		
High School or less	11.4%	6.3%
College (1-4)	8.6%	6.5%
Graduate / Professional	6.4%	4.2%
Employment		
Full-time	8.1%	6.3%
Part-time	18.2%	7.8%
Unemployed	24.0%	15.4%
Other	4.1%	3.5%

Source: District of Columbia, Department of Health, Addiction Prevention and Recovery Administration, 2000 Household Survey on Substance Abuse: Main Findings, September 2001 and Department of Health and Human Services, "Summary of Findings from the 2000 National Household Survey on Drug Abuse," September 2001.

Table A-8

Percentage Reporting Past Month Use of Illicit Drugs, Total and by Age Group

	Total	12-17	18-24	25-34	35+
Any Illicit Drug	**9.6%**	7.4%	20.5%	14.0%	6.4%
Marijuana	**6.9%**	7.0%	16.7%	12.6%	3.2%
Cocaine	**2.4%**	1.2%	2.5%	4.5%	1.8%
Heroin	**0.4%**	• • •	• • •	0.1%	0.6%
Inhalants	**0.6%**	• • •	• • •	0.4%	0.8%
Hallucinogens	**0.5%**	• • •	1.0%	2.1%	• • •

Source: District of Columbia, Department of Health, Addiction Prevention and Recovery Administration, 2000 Household Survey on Substance Abuse: Main Findings, September 2001.

• • • Low Precision, no estimate reported.

Table A-9

Percentage Reporting Illicit Drug Use in Their Lifetime, Past Year, and Past Month, by Age

	Lifetime	Past Year	Past Month
Total	**46.1%**	**17.9%**	**9.6%**
12-17	24.8%	20.6%	7.4%
18-24	55.3%	36.2%	20.5%
25-34	57.3%	23.8%	14.0%
35+	42.8%	12.2%	6.4%

Source: District of Columbia, Department of Health, Addiction Prevention and Recovery Administration, 2000 Household Survey on Substance Abuse: Main Findings, September 2001.

Table A-10

Percentage Reporting Illicit Drug Use in Their Lifetime, Past Year, and Past Month, by Ward

Ward	Lifetime	Past Year	Past Month
1	51.6%	16.5%	12.6%
2	52.4%	21.3%	14.1%
3	54.2%	13.1%	2.7%
4	15.7%	5.6%	3.0%
5	46.8%	22.2%	14.0%
6	57.2%	25.7%	5.3%
7	35.7%	19.7%	12.3%
8	54.6%	20.2%	11.3%

Source: District of Columbia, Department of Health, Addiction Prevention and Recovery Administration, 2000 Household Survey on Substance Abuse: Main Findings, September 2001.

Table A-11

Comparison of the National and District (APRA) Household Survey Estimates of the District Noninstitutionalized Population Aged 12 or Older Reporting Use of Selected Drugs in the Past Month by Age Group

Drug Characteristic	Total		AGE GROUP (YEARS) 12-17		18-25	18-24	26 & Older	25 & Older
			National	APRA				
			Rate Estimates (Percent)					
Any Illicit Drug	6.3%	9.6%	9.7%	7.4%	15.9%	20.5%	4.2%	8.3%
Marijuana	4.8%	6.9%	7.2%	7.0%	13.6%	16.7%	3.0%	5.6%
Any Illicit Drug Other Than Marijuana	2.6%	7.2%	4.6%	1.6%	5.9%	12.4%	1.7%	6.9%
Cigarettes	24.9%	25.7%	13.4%	12.1%	38.3%	31.8%	24.2%	25.9%
Binge Alcohol	20.6%	17.2%	10.4%	8.0%	37.8%	29.2%	19.1%	16.2%
			Population Estimate (In Thousands)					
Any Illicit Drug	14,027	41	2,264	2	4,599	10	7,164	29
Marijuana	10,714	30	1,678	2	3,950	8	5,085	20
Any Illicit Drug Other Than Marijuana	5,711	31	1,074	0.4	1,711	6	2,926	24
Cigarettes	55,667	109	3,140	3	11,095	16	41,432	91
Binge Alcohol	46,049	73	2,438	2	10,964	14	32,647	57

Note: The age grouping for the National Household Survey (12-17, 18-25 and 26 and Older) varies slightly from the age grouping for the APRA Household Survey (12-17, 18-24 and 25 and Older). Sources: *District of Columbia, Department of Health, Addiction Prevention and Recovery Administration, 2000 Household Survey on Substance Abuse: Main Findings, September 2001 and Department of Health and Human Services, "Summary of Findings from the 2000 National Household Survey on Drug Abuse," September 2001.*

Table A-12

Percentage of and Estimated Number in the District of Noninstitutionalized Population Aged 12 or Older Reporting Dependence on Selected Drugs and Alcohol by Age, Gender, Race and Ward

Demographic Characteristic	Drug Type or Category						
	Illicit Drug	Illicit Drug or Alcohol	Alcohol	Marijuana	Cigarettes	Cocaine	Heroin
Total Age	**3.7%**	**8.9%**	**6.9%**	**2.4%**	**6.7%**	**1.8%**	**0.6%**
12 to 17	3.2%	3.2%	2.0%	3.2%	2.0%	0.4%	***
18 to 24	9.8%	18.9%	14.0%	9.8%	11.4%	1.3%	***
25 to 34	5.0%	11.0%	8.5%	3.7%	6.2%	3.3%	0.1%
35 to 64	2.7%	8.7%	7.1%	0.8%	7.6%	2.0%	0.1%
65 +	0.4%	0.4%	***	***	2.7%	***	0.4%
Gender							
Male	5.6%	11.6%	8.3%	4.2%	8.6%	2.2%	1.0%
Female	2.1%	6.5%	5.6%	0.9%	5.1%	1.4%	0.2%
Race							
White	1.2%	10.5%	10.3%	1.0%	2.6%	0.7%	0.3%
Black	5.5%	8.8%	5.6%	3.5%	9.4%	2.5%	0.8%
Hispanic	0.4%	1.7%	1.2%	***	0.8%	0.4%	***
Other	***	3.6%	3.6%	***	11.1%	***	***
Ward							
One	2.7%	7.2%	6.4%	2.3%	6.8%	1.9%	0.4%
Two	2.7%	6.3%	5.7%	2.0%	6.8%	0.8%	1.1%
Three	***	8.0%	8.0%	***	0.3%	***	***
Four	0.9%	2.1%	1.2%	0.1%	1.1%	0.9%	***
Five	7.7%	12.3%	9.5%	6.4%	12.9%	4.3%	0.5%
Six	6.9%	18.4%	13.1%	4.1%	10.7%	1.9%	1.0%
Seven	3.5%	6.1%	3.8%	1.2%	7.5%	1.9%	0.8%
Eight	7.1%	12.5%	7.8%	4.3%	9.0%	3.5%	0.9%
			(Population Estimates)				
Total Age	**15,766**	**37,714**	**29,224**	**10,415**	**28,505**	**7,600**	**2,405**
12 to 17	837	837	527	837	529	94	***
18 to 24	4,827	9,346	6,919	4,827	5,609	636	***
25 to 34	4,388	9,608	7.369	3,201	5,376	2,838	604
35 to 64	5,498	17,707	14,409	1,550	15,370	4,032	1,585
65 +	216	216	***	***	1,621	***	216
Gender							
Male	11,055	22,910	16,384	8,313	16,968	4,388	1,969
Female	4,710	14,805	12,839	2,102	11,538	3,212	435
Race							
White	1,647	14,463	14,258	1,443	3,548	1,003	367
Black	14,004	22,591	14,418	8,972	24,029	6,483	2,037
Hispanic	114	431	317	***	214	114	***
Other	***	231	231	***	716	***	***
Ward							
One	1,636	4,432	3,938	1,420	4,220	1,142	216
Two	1,620	3,872	3,491	1,239	4,144	494	670
Three	***	4,552	4,552	***	189	***	***
Four	456	1,108	652	73	564	456	***
Five	3,854	6,179	4,767	3,194	6,471	2,143	269
Six	3,483	9,303	6,664	2,090	5,447	953	506
Seven	1,749	3,001	1,861	588	3,699	931	378
Eight	2,967	5,267	3,298	1,811	3,771	1,482	365

Note: Questions on problems indicative of dependence were similar to those used in the National Household Survey on Drug Abuse patterned after Diagnostic and Statistical Manual of Mental Disorder, 4th edition. Experience of three or more of the seven problems associated with the use of any substance in the past 12 months was considered dependence.
*** Low precision; no estimate reported

Table A-13

Prevalence of Monthly Drug Use among 6th-8th, 9th-12th and 12th graders, according to PRIDE 1994-95 through 1999-00

	Monthly use (Percent)						
	1994-95	1995-96	1996-97	1997-98	1998-99	1999-00	Change*
Cigarettes							
6th-8th	15.7	17.2	17.3	15.6	13.2	9.6	-3.6*
9th-12th	31.3	33.4	34.7	33.9	31.1	28.7	-2.4*
12th	34.6	36.2	38.3	40.7	37.5	36.3	-1.2*
Beer							
6th-8th	11.8	12.5	12.1	10.7	10.2	8.7	-1.5*
9th-12th	33.3	34.3	34.4	31.9	31.5	30.9	-0.6*
12th	40.6	41.2	41.7	41.0	39.9	39.1	-0.8
Wine Coolers							
6th-8th	9.8	10.8	10.8	9.9	9.6	8.7	-0.9*
9th-12th	23.1	22.3	22.3	21.4	22.9	22.0	-0.9*
12th	25.6	22.9	23.7	23.9	25.5	24.7	-0.8
Liquor							
6th-8th	8.5	9.0	9.1	8.0	8.0	6.5	-1.5*
9th-12th	27.4	28.2	28.7	26.9	28.1	27.6	-0.5
12th	32.5	32.8	34.0	34.1	35.3	35.4	+0.1
Marijuana							
6th-8th	5.7	8.1	8.6	7.1	6.5	5.2	-1.3*
9th-12th	18.5	22.3	22.7	20.8	20.3	19.3	-1.0*
12th	20.9	24.3	24.4	23.6	23.1	23.4	+0.3
Cocaine							
6th-8th	1.2	1.5	1.7	1.6	1.5	1.3	-0.2*
9th-12th	2.6	2.9	3.0	3.1	3.2	2.9	-0.3*
12th	2.9	3.6	3.6	4.0	4.1	3.6	-0.5*
Uppers							
6th-8th	2.0	2.4	2.6	2.5	2.1	1.7	-0.4*
9th-12th	5.1	5.2	5.3	5.4	5.0	5.2	+0.2
12th	5.6	5.8	5.6	6.3	5.8	6.2	+0.4
Downers							
6th-8th	1.5	1.9	2.1	1.9	1.7	1.4	-0.3*
9th-12th	3.4	3.8	3.8	4.2	4.0	4.1	+0.1
12th	3.6	4.1	3.9	4.9	4.5	4.8	+0.3
Inhalants							
6th-8th	2.9	3.5	3.7	3.3	2.7	2.3	-0.4*
9th-12th	3.5	3.4	3.1	3.1	3.0	2.7	-0.3*
12th	3.0	3.1	2.7	2.8	3.0	2.7	-0.3*
Hallucinogens							
6th-8th	1.5	1.8	2.0	1.8	1.7	1.4	-0.3*
9th-12th	4.1	4.5	4.2	3.9	4.2	3.6	-0.6*
12th	4.8	5.1	4.6	4.5	5.2	4.4	-0.8*

*Difference between the 1998-99 and 1999-00 surveys.

	Sample sizes					
Grade	**1994-95**	**1995-96**	**1996-97**	**1997-98**	**1998-99**	**1999-2000**
6th-8th	92,453	58,596	68,071	68,149	58,619	59,243
9th-12th	105,788	70,964	73,006	86,201	79,460	55,075
12th	20,698	14,261	15,532	15,816	16,366	11,680

Source: *PRIDE Questionnaire Report*, 1994-95, 1995-96, 1996-97, 1997-98, 1998-99, and 1999-00.Table A-14

Table A-14
Drug-Related Deaths in the Washington DC Metropolitan Area

	1997	1998	1999	2000	2001
Alcohol	84	103	85	81	66
Cocaine	81	121	106	107	90
Heroin	107	117	95	84	64

Source: Department of Health and Human Services, "Mortality Data from the Drug Abuse Warning Network, 2001" Substance Abuse and Mental Health Services Administration.

Table A-15
Income and Selected Drug-Related Consequence Indicators by Ward

	D.C.	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Ward 7	Ward 8
1998 per capita income	$29,383	$25,983	$39,225	$63,340	$24,566	$20,528	$27,800	$17,743	$12,651
1997 homicide death rate (per 10,000 residents)	4.45	4.45	1.86	0.27	3.19	5.32	6.81	8.41	7.02
1999 low birth-weight rate (percent)	13.3%	11.5%	10.9%	6.4%	12.6%	17.3%	14.1%	16.5%	16.0%
1997 new IDU-related AIDS cases (per 10,000 residents)	6.30	4.86	3.35	<.55	5.65	5.62	4.94	6.39	8.39
Percent of D.C. adults who personally know a city resident with an alcohol problem	49%	46%	40%	41%	51%	59%	55%	54%	48%
Percent of D.C. adults who personally know a city resident who regularly uses illegal drugs	35%	37%	27%	20%	41%	37%	38%	37%	45%

Sources: D.C. Office of Planning/State Data Center, September 1, 1999
D.C. State Center for Health Statistics, Vital Statistics Data Sheet, 1999.
D.C. Administration for HIV/AIDS, 1998
Peter D. Hart Research Associates, 1998

Table A-16

Percentage of Alternative High School Students Who Used Selected Drugs by Sex, Race/Ethnicity, and Grade, 1998

Drug Use Behavior	SEX		RACE/ETHNICITY			GRADE LEVEL				All GROUPS
	Male	Female	White, non-Hispanic	Black, non-Hispanic	Hispanic	9th	10th	11th	12th	
Lifetime marijuana	88.0	82.1	89.4	77.7	84.0	81.0	85.3	86.0	86.8	85.4
Current marijuana[1]	58.2	46.7	56.7	47.2	50.6	51.2	52.9	55.7	51.2	53.0
Lifetime cocaine use[2]	38.6	33.0	43.8	5.7	46.4	32.7	36.4	37.8	36.5	36.1
Current cocaine use[1]	17.1	13.1	17.1	3.6	19.4	14.8	16.6	15.9	14.1	15.3
Lifetime crack or freebase use	23.5	19.4	26.2	3.5	26.8	20.9	22.9	24.2	18.9	21.6
Lifetime use of illegal steroids	9.8	7.4	10.5	6.6	6.9	12.0	9.6	6.9	7.6	8.7
Lifetime injected drug use	6.8	4.4	7.0	4.1	4.5	7.6	5.6	5.4	4.9	5.7
Episodic heavy drinking[3]	55.4	42.9	58.7	28.4	52.4	43.8	48.1	51.5	51.7	49.8
Current cigarette[1]	67.7	59.8	78.6	43.3	53.0	64.5	64.3	64.8	62.2	64.1

[1] Used one or more times during the last 30 days.
[2] Ever tried any form of cocaine, including powder, crack, or freebase.
[3]Drank five or more drinks of alcohol on at least one occasion on one or more days during the last 30 days.

Source: *Morbidity and Mortality Weekly Report*, "Youth Risk Behavior Surveillance-National Alternative High School Youth Risk Behavior Survey, United States, 1998," Centers for Disease Control and Prevention, Public Health Service, Department of Health and Human Services.

Table A-17
Annual Crime Trends, District of Columbia, 1996-2002

	1998	1999	2000	2001	2002
Homicide	260	241	242	233	262
Forcible Rape	190	248	251	181	NA
Robbery	3,606	3,344	3,553	3,777	NA
Aggravated Assault	4,932	4,616	4,582	5,003	NA
Burglary	6,361	5,067	4,745	4,947	NA
Theft	24,321	21,673	21,637	22,274	NA
Stolen Auto	6,501	6,652	6,600	7,970	NA
Arson	119	105	108	104	NA
Total	**46,290**	**41,946**	**41,718**	**44,489**	**NA**

Source: *Metropolitan Police Department Web Site, "Citywide Crime Statistics Annual Totals."*

Table A-18
Substance Abuse Arrests, 1998-2002

	1998	1999	2000	2001	2002
Adults					
Drug Sales	937	1,544	1,149	1,538	1,478
Drug Possessions	5,218	5,128	5,063	4,793	4,482
Driving Under Influence	2,112	1,579	1,593	1,615	1,332
Liquor Law	200	106	139	287	306
Subtotal	**8,467**	**8,357**	**7,944**	**8,233**	**7,598**
Juveniles					
Drug Sales	94	122	95	128	106
Drug Possessions	444	419	381	318	251
Driving Under Influence	0	0	0	1	0
Liquor Law	1	1	2	2	0
Subtotal	**539**	**542**	**478**	**449**	**357**
Total	**9,006**	**8,899**	**8,422**	**8,682**	**7,955**
All MPD Arrests	**63,026**	**59,009**	**57,151**	**49,692**	**46,247**

Table A-19
Percent of Adult Male Arrestees Testing Positive for Drugs, District of Columbia, 1999

Offense Type	Cocaine	Marijuana	Metham.	PCP	Any Drug
Violent	23.5%	35.3%	0.0%	0.0%	52.9%
Property	45.0	35.0	0.0	5.0	75.0
Drug	44.1	50.0	2.9	5.9	85.3
Sales	23.1	61.5	0.0	7.7	76.9
Possession	52.2	47.8	4.3	8.7	91.3
Other	37.2	20.9	0.0	7.0	58.1

Source: *Department of Justice, Office of Justice Programs, "ADAM Preliminary Findings on Drug Use and Drug Markets" December 2001*

Table A-20
Percent of Juvenile Male Arrestees Testing Positive for Drugs, District of Columbia, 1998

Offense Type	Cocaine	Marijuana	PCP	Any Drug
Violent	0.0	42.9	3.6	46.4
Property	3.3	36.7	0.0	36.7
Drug	3.2	77.4	6.5	77.4
Other	6.9	69.0	0.0	75.9
Total	3.4	56.8	2.5	59.3

Source: *Department of Justice, Office of Justice Programs, "ADAM Preliminary Findings on Drug Use and Drug Markets" April 1999*

Table A-21

Trends in Illicit Drug-Related Emergency Room Episodes and Selected Drug Mentions in the District of Columbia Metropolitan Area, 1988-99

Emergency room episodes and drug mentions

Year	Total drug episodes	Total drug mentions	Total cocaine mentions	Total heroin mentions	Total marijuana mentions
1992	10,687	18,329	4,236	1,512	1,259
1993	12,339	21,692	4,275	1,414	2,102
1994	14,152	25,222	4,849	1,261	2,712
1995	11,830	19,896	3,542	1,307	2,035
1996	11,720	19,815	3,881	1,535	2,167
1997	11,194	18.975	3,223	1,691	2,394
1998	11,596	19,068	3,718	2,112	2,362
1999	10,282	16,936	3,150	1,771	2,516
2000	10,303	16,229	2,830	1,946	2,510
2001	10,566	17,480	2,894	1,888	2,135

Source: *Drug Abuse Warning Network*, National Institute on Drug Abuse (1988-91) and Substance Abuse and Mental Health Services Administration (2002)

Table A-22

Rate of Emergency Department Episodes per 100,000 Population, District of Columbia Metropolitan Area and the U.S.

	DC	US
1992	296	191
1993	338	201
1994	386	225
1995	319	221
1996	313	219
1997	295	222
1998	303	225
1999	266	228
2000	262	243
2001	253	252

Source: *Drug Abuse Warning Network*, Substance Abuse and Mental Health Services Administration (2002)

Table A-23

Individuals Receiving Treatment Provide by or Paid for by Government Funding*

	D.C.	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Ward 7	Ward 8
1998	6661	599	666	35	666	999	1032	1099	1099
1997	5503	605	605	30	550	880	715	825	908
1996	6620	927	662	34	662	993	794	927	959
1995	6987	978	699	70	699	1048	908	978	908

Sources: Addiction Prevention Recovery Administration

*Duplicate count

Table A-24

Substance Abuse Treatment Admissions by Primary Substance of Abuse, According to Sex, Age, and Race, District of Columbia, 1999

	Total		Alcohol		Opiates		Cocaine		Marijuana	Other
	Number	Percent	Alcohol Only	With secondary drug	Heroin	Other	Smoked	Other		
Total Number	**6,005**		821	410	1,744	21	1,925	300	750	
Total Percent		**100.00**	13.7	6.8	29.0	0.3	32.1	5.0	12.5	
					(Percent)					
Gender										
Male	**4,257**	**70.9**	85.4	75.9	67.0	71.4	60.8	68.3	88.1	
Female	**1,748**	**29.1**	14.6	24.1	33.0	28.6	39.2	31.7	11.9	
Use at Admission										
< 15	**19**	**0.3**	0.2	0.7	0.1		0.1		1.3	
15 – 17	**40**	**0.7**	0.4	1.7	0.1		0.1		3.6	
18 – 20	**193**	**3.2**	2.8	2.2	0.3		0.8	1.0	17.9	6.5
21 – 25	**427**	**7.1**	6.7	6.1	1.4	4.8	2.7	5.7	31.7	41.9
26 – 30	**587**	**9.8**	9.3	11.2	3.2		11.1	12.0	20.1	29.0
31 – 35	**1,052**	**17.5**	14.0	20.7	11.3	23.8	25.7	21.0	11.6	16.1
36 – 40	**1,368**	**22.8**	19.4	24.1	22.7	19.0	30.0	26.3	7.1	3.2
41 – 45	**1,150**	**19.2**	16.4	16.8	29.9	23.8	18.2	15.7	3.1	
46 – 50	**700**	**11.7**	11.2	9.8	21.2	14.3	7.3	12.0	2.5	3.3
51 +	**467**	**7.7**	19.6	6.6	9.8	14.3	4.1	6.3	1.0	

Source: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration, Office of applied Studies, Treatment Episode Data Set (TEDS). 1999.

Table A-25

Substance Abuse Treatment Facilities by Ownership, 1999

	Number	Percent
Total	**58**	**100.0**
Private Non-Profit	34	58.6
Private For-Profit	13	22.4
Local/State	9	15.5
Federal Government	2	3.4

Source: U.S. Department of Health and Human Services, National Survey of Substance Abuse Treatment Services, 2000.

Table A-26
Substance Abuse Treatment Facilities in Washington, D.C., Number and Percent

	Number	Percent
Total	**58**	
Out patient		
Detox	10	17.2.0
Non-Intensive Rehab.	40	69.0
Partial Hospitalization	16	20.7
Residential		
Detox	3	5.2
Rehab.	16	27.6
Hospital Inpatient		
Detox	7	12.1
Rehab.	4	6.9
Methadone/LAAM	13	22.4

Source: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services, 2000.

Table A-27
Substance Abuse Treatment Facilities by Substance Abuse Problem Treated, 1999

	Number	Percent
Total	**56**	**100.0**
Drug and Alcohol	52	92.9
Drug abuse Only	4	7.1
Alcohol Only		--

Source: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services, 2000.

Table A-28
Substance Abuse Facilities by Primary Focus, 1999

	Number	Percent
Total	**58**	**100.0**
Substance Abuse Services	38	65.5
Mental Health Services	5	8.6
Balance of SA and MH Services	13	22.4
General Health Services	2	3.4
Other	--	--

Source: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services, 2000.

Table A-29
APRA Screening and Detox/Treatment Figures: FY 01 and FY 02

	FY 00	FY 01	FY 02
Screened at Detox	2,478	4,933	1,843
Admitted to Detox	3,271	3,765	1,615
Screened at CID	2,059	4,581	800
Screened Other	3,859	1,090	1,873
Total Admission	6,175	10,604	4,481
Totals Treated in APRA	8,534	12,948	6,852

Appendix B

INVENTORY OF SUBSTANCE ABUSE-RELATED PROGRAMS AND RESOURCES

SUMMARY OF SUBSTANCE ABUSE SERVICES IN THE DISTRICT OF COLUMBIA

Chapter 3 of this Substance Abuse Strategy (Strategy) provides an overview of the amount of money spent in the District on substance abuse-related services. This appendix provides the details on the involvement of each department and agency in the District that provides substance abuse-related services. Each section includes a summary table showing expenditures in total, by agency or program, and by functional area. In addition, each section provides a short narrative that details the population served and specific services provided by the department or agency.

CHILD AND FAMILY SERVICES AGENCY (CFSA)

(dollars in thousands)

Agency/Program	FY 2003	FY 2004
CFSA	$1,857.9	$1,400.0
Funding Source		
DC Budget	$1,244.8	$938.0
Federal	613.1	462.0
Total	$1,857.9	$1,400.0
Function		
Treatment	$1,857.9	$1,400.0

Population Served

The Child and Family Services Agency (CFSA) serves children and youths (0-21 years) who have been or are at risk of being abused or neglected. The CFSA also serves the parents/guardians who have abused or neglected children in their care or are at risk for this behavior.

Substance Abuse-Related Services

CFSA is involved with case management tasks: ongoing child/family risk and safety assessments, recommendations to court regarding removal or reunification of abused/neglected children, crisis intervention, face-to-face visits with child and family,

consultation and training, and linkage/referral to substance abuse services. CFSA monitors substance abuse treatment progress for those people in its case management system and provides recommendations to treatment programs regarding the appropriate continuum of care.

COURT SERVICES AND OFFENDER SUPERVISION AGENCY (CSOSA)

(dollars in thousands)

Agency/Program	FY 2003	FY 2004
CSOSA	$11,100.0	$11,100.0
Funding Source		
Federal	$11,100.0	$11,100.0
Function		
Treatment	$11,100.0	$11,100.0

Population Served

The Court Services and Offender Supervision Agency (CSOSA) works with adult probationers, parolees, and supervised releases held under the authority of the United States or District of Columbia statute and entrusted to CSOSA for community supervision.

Substance Abuse-Related Services

CSOSA provides a broad range of services to people under its supervision. CSOSA supports a variety of treatment modalities including detoxification, 28-day residential, 120-day residential, 90-day supervised transitional (the 120-day and 90-day programs are also available to women with children), and outpatient services. CSOSA also provides "halfway-back" services, traffic alcohol education, in-house services, acupuncture therapy, and drug testing.

DEPARTMENT OF CORRECTIONS (DOC)

(dollars in thousands)

Agency/Program	FY 2003	FY 2004
Prisoner Security	$35,000.0	$35,000.0
Assessment/ Treatment/Support	7,981.0	7,981.0
Total	$42,981.0	$42,981.0
Funding Source		
DC Budget	$42,646.1	$42,646.1
Federal	334.9	334.9
Total	$42,981.0	$42,981.0
Function		
Treatment	$3,740.7	$3,740.7
Corrections	39,240.3	39,240.3
Total	$42,981.0	$42,981.0

Population Served

The Department of Corrections (DOC) provides custody, security, food service, and health care for all inmates within its facilities. An integral component of the intake process for all incarcerated individuals includes substance abuse assessment and screening for possible referral for more intensive intervention by mental health or medical services. Substance abuse prevention and prevention education services are also provided to all inmates.

Substance Abuse-Related Services

The following substance abuse-related services are provided to DOC inmates who

require them or meet the criteria for participation: substance abuse assessment and screening, methadone maintenance, alcohol detoxification referral, substance abuse withdrawal, substance abuse prevention education, substance abuse treatment readiness, substance abuse treatment and urine analysis. DOC has operated a substance abuse treatment readiness program, the Safety Net Program, for the past three years at the Central Detention Facility, which provides treatment readiness programming using cognitive-behavioral restructuring principles as the therapeutic modality. This program is currently available to 100 inmates, 80 males and 20 females. This program is available through funding from the Department of Health (DOH), under a memorandum of understanding between the Department of Corrections and the Addiction Prevention and Recovery Administration. The program involves establishing comprehensive substance abuse treatment readiness to minimize, reduce, or prevent the dependency of inmates on illegal substances. DOC has recently been awarded funding to provide a six-month substance abuse treatment program for a total of 60 inmates, 40 males and 20 females. This program will also be rooted in cognitive-behavioral restructuring principles with a heavy emphasis on coordination of aftercare. DOC also provides substance abuse treatment services to 90 inmates housed at the privately managed and operated Correctional Treatment Facility/Corrections Corporation of America (CTF/CCA), utilizing a variety of treatment modalities.

DEPARTMENT OF HEALTH (DOH)

(dollars in thousands)

Agency/Program	FY 2003	FY 2004
APRA	$36,524.7	$34,298.0
HIV/AIDS Admin	1,490.3	1,490.3
MFHA	127.0	---
Medical Affairs	2,755.1	1,920.5
UDC Student Clinic	22.0	---
Total	$40,919.1	$37,708.8
Funding Source		
DC Budget	$25,354.2	$22,851.9
Federal	12,377.3	12,186.5
Other	885.2	390.0
Not Identified	2,302.3	2,280.3
Total	$40,919.1	$37,708.8
Function		
Prevention	$3,139.4	$843.3
Treatment	37,779.7	36,865.5
Total	$40,919.1	$37,708.8

Population Served

Addiction, Prevention, and Recovery Administration (APRA): APRA serves numerous special populations, including women; youths; seniors; people in jail; those with HIV/AIDS; gay, bi-sexual, lesbian, and transgender individuals; Latinos, Asians, and Pacific Islanders; and others. In addition, the APRA Certification Unit works with Narcotics (Opioid) Treatment Programs and outpatient (youth and adult) jail-based detoxification and residential substance abuse treatment facilities and programs operating in the District of Columbia.

HIV/AIDS Administration: The HIV/AIDS Administration provides substance abuse-related services to injection drug users as well as individuals living with

HIV/AIDS who are dually diagnosed with substance abuse.

Maternal and Family Health Administration (MFHA): MFHA serves teen mothers and clients in the Healthy Start and Health Line programs.

Medical Affairs/Communicable and Chronic Disease: The Tuberculosis Administration within Medical Affairs serves all residents of the District, providing screening, diagnosis, treatment, and after care for tuberculosis (TB). In 2001, approximately 16 percent of TB cases had a secondary diagnosis of substance abuse.

In addition, Medical Affairs provides services to those people in need of medical services that address sexually transmitted disease (STD) or risky behavior.

University of the District of Columbia (UDC) Student Clinic: The UDC Student Clinic serves about 2,000 women and 1,500 men annually. In addition, the clinic offers a smoking cessation program that serves about 50 women and 30 men per year.

Substance Abuse-Related Services

APRA: With more than a dozen programs and activities devoted to providing or supporting substance abuse services for residents of the District of Columbia, APRA is a key component of the city's efforts to reduce substance abuse and its consequences. APRA provides or oversees diagnosis, treatment (including in-patient and out-patient), and treatment referrals. APRA is also involved with prevention efforts including education, educational outreach and counseling intervention.

Pursuant to Title 29 DCMR, Chapter 23 and Chapter 24, APRA has the responsibility for the inspection, monitoring, and certification of all residential substance abuse treatment facilities operating within the District of Columbia. In addition, pursuant to DCMR, Chapter 24, APRA has the responsibility for the inspection, monitoring and certification of all substance abuse treatment programs wishing to participate in the Drug Treatment Choice Program (DTCP).

HIV/AIDS Administration: The HIV/AIDS Administration provides prevention education and referral services together with HIV support programs to injection drug users. The administration also supports outpatient and residential substance abuse treatment for those individuals living with HIV/AIDS who are dually diagnosed with substance abuse.

Maternal and Family Health Administration (MFHA): MFHA provides substance abuse-related services through the Teen Mothers Take Charge program. The grants are provided to community-based organizations and include case management and education for teen mothers. MFHA also provides services through Healthy Start and Health Line including substance abuse referrals, case management, education, and referrals to clients with HIV/AIDS, and nicotine addiction.

Medical Affairs/Communicable and Chronic Disease: A comprehensive evaluation is conducted on new patients with TB. The Tuberculosis Administration supports home visits, case contact investigation and directly observed therapy as well as follow-up visits for medication refills and monthly evaluations for those diagnosed with TB. Patient education regarding TB, substance abuse, and other social and medical issues are an integral part of the case management for those with TB. In addition, referrals to substance abuse treatment providers are made for those patients determined to be in need of such services.

Medical Affairs also provides examination, diagnosis, and treatment of sexually transmitted diseases.

University of the District of Columbia (UDC) Student Clinic: The UDC Student Clinic has two programs that support the District's efforts to reduce substance abuse. The clinic provides screening questionnaires and conducts special one-week outreach programs. The UDC Student Clinic also supports a smoking cessation program that was initiated in spring 2003.

DISTRICT OF COLUMBIA HOUSING AUTHORITY (DCHA)

(dollars in thousands)

Agency/Program	FY 2003	FY 2004
DCHA	$850.0	---
Funding Source		
Federal	$850.0	---
Function		
Prevention	$850.0	---

Population Served

The District of Columbia Housing Authority (DCHA) services all residents of public housing in the District of Columbia.

Substance Abuse-Related Services

Substance abuse-related costs to the DCHA come mainly in the form of Fight Back Evictions and the repairs of damage done to public housing property by drug users and drug dealers.

Fight Back costs include Fight Back evictions, the renovation of units, and lost rent during the time the units are unoccupied. The average eviction cost totals almost $4,000 with the cost of the eviction at about $300 and the cost of renovation for the unit averaging $3,500. In addition, costs resulting from damage from drug users and drug dealers are substantial and includes such things as door and door lock replacement and repair, the installation and repair of security bars in stairwells and remote areas, replacement of broken windows, installation and maintenance of security cameras, and boarding up of vacant units.

DEPARTMENT OF HUMAN SERVICES (DHS)

(dollars in thousands)

Agency/Program	FY 2003	FY 2004
Off. of Early Childhood Development	$53.4	$53.4
Family Services Admin.	114.3	114.3
Office of General Counsel	2.5	1.5
Income Maintenance Admin.	998.7	998.7
Rehab. Services Admin.	396.0	435.6
Youth Services Admin.	4,226.4	4,287.7
Total	$5,791.3	$5,891.3
Funding Source		
DC Budget	$5,293.3	$5,361.7
Federal	498.0	529.6
Total	$5,791.3	$5,891.3
Function		
Prevention	$2,946.3	$3,046.2
Treatment	2,845.1	2,845.1
Total	$5,791.3	$5,891.3

Population Served

Office of Early Childhood Development (OECD): The OECD serves children age 6 weeks through 12 years and children with disabilities up to age 19 throughout the District of Columbia.

Family Services Administration (FSA): The FSA provides services to single homeless adults and homeless people in families. About 6,350 single homeless adults and 450 homeless people in families are currently being served by FSA.

Office of General Counsel (OGC): The OGC provides legal review for the Department of Human Services.

Income Maintenance Administration (IMA): The IMA provides services to those adult recipients of Temporary Assistance for Needy Families (TANF) who have incapacities due to substance abuse that prevent them from complying with and participating in work requirements. Individuals with incapacities are enrolled in the Program on Work, Employment and Responsibility (POWER) and are referred to the Addiction Prevention and Recovery Administration (APRA) for services.

Rehabilitation Services Administration (RSA): The RSA provides services to clients who meet the eligibility requirements. In FY 2003, the RSA expects to serve 2,100 individuals. In FY 2004, the total number of individuals served is expected to increase to over 2,300 clients.

Youth Services Administration (YSA): Youth who are committed to DHS/YSA are provided outpatient substance abuse treatment, relapse prevention, and drug screening through community-based contractors. The services are available to youth residing at home or in local community-based placements. Youth and their families can typically receive up to 40 hours of services per month. The YSA also contracts for inpatient non-hospital substance abuse treatment, inpatient hospital substance abuse treatment, and substance abuse services at the Oak Hill Youth Center. Memorandum Order B, which was issued subsequent to the Jerry M. Consent Decree, requires YSA to establish a continuum of care for youth including youth in families with substance abuse issues. In response to Memorandum Order B, YSA contracts with providers for the following community-based substance abuse-related services: home-based counseling and support services, after-school enrichment, mentoring and intensive supervision. The contracted community-based services are available to the committed population only, with the exception of intensive supervision services, which is available to the detained juvenile justice population.

Substance Abuse-Related Services

Office of Early Childhood Development (OECD): The OECD provides subsidized child care for eligible families throughout the District of Columbia through child development facilities. In addition, many child development facilities participating in the child care subsidy program provide support and referral services for parents who are homeless or receiving substance abuse treatment. These services are supported by other funding sources and include assistance in obtaining housing, parenting classes, clothing, and food.

Family Services Administration (FSA): The FSA provides case management and referral services to homeless individuals and homeless people in families who are in need of substance abuse treatment.

Office of General Counsel (OGC): The OGC reviews for legal sufficiency memoranda of understanding between the Department of Human Services and other departments and agencies within the District government. Expenditure levels represent costs for the review for legal sufficiency for memoranda of understanding related to substance abuse activities.

Income Maintenance Administration (IMA): The IMA has a memorandum of understanding with the Addiction Prevention and Recovery Administration (APRA) to provide substance abuse treatment and prevention services to individuals who meet the eligibility requirements of TANF and who have been enrolled in POWER.

Rehabilitation Services Administration (RSA): For those individuals who meet program requirements, the RSA conducts a vocational rehabilitation eligibility determination. Clients receive vocational rehabilitation case management services, including employment assistance.

Youth Services Administration (YSA): The YSA provides the following types of substance abuse-related services for youth committed to DHS/YSA.

- *Home-based Counseling and Support Services*--Services provided in the home environment to stabilize crises, address problem areas and/or to increase the general stability of the home environment. These services provide support to the youth and/or family members by providing immediate, intensive, problem-specific interventions to youth and their families.
- *Adult School Enrichment*--Services that may provide one or more of the following: general supervision, skill building, study skills, educational tutoring, recreation, and leisure activities.
- *Mentoring*--Services that link youth with an adult who serves as an adviser, advocate and role model. Mentors work with the youth in the home, school and in the community to promote the development of positive pro-social behavior, leisure activities, and interpersonal skills
- *Intensive Supervision*--Services provided to ensure that committed and detained youth comply with court-ordered rules, including frequent visual and phone contact, strict monitoring of behavior, and individual and family counseling. Additionally, YSA provides substance abuse education-related services to the detained population under the supervision of Court Social Services. The services provided to the detained population are contracted and agency managed intensive supervision services.

DEPARTMENT OF MENTAL HEALTH (DMH)

(dollars in thousands)

Agency/Program	FY 2003	FY 2004
Dept. of Mental Health	$89,676.7	$90,188.0
Funding Source		
DC Budget	$59,615.3	$59,722.7
Federal	29,291.5	30,465.3
Other	770.0	---
Total	$89,676.7	$90,188.0
Function		
Prevention	$1,074.7	$1,182.2
Treatment	88,602.0	89,005.8
Total	$89,676.7	$90,188.0

The Department of Mental Health has a number of programs and activities that provide substance abuse-related services. Although these programs and activities were not detailed in the Table above, a more detailed description of the department's substance abuse-related services is provided below.

Population Served

St. Elizabeth's Hospital: St. Elizabeth's Hospital provides mental health services to residents of the District of Columbia.

Comprehensive Psychiatric Emergency Program (CPEP): Services are offered to individuals over 18 years of age who are in crisis.

Community Contract Providers: Mental health services are provided to children and adults in the District of Columbia.

Public Core Services Agency: Mental health services are provided to children and adults in the District of Columbia.

Integrated School-Based Mental Health Budget: All youths in schools where the program is operating are eligible to participate in this program.

Homeless Support Services and DC Pathways Grant: People in the District of Columbia who are homeless are eligible to participate in this program.

Substance Abuse-Related Services

St. Elizabeth's Hospital: All of the health care-related expenses of people being treated for co-occurring substance abuse and mental health disorders are considered to be substance abuse-related. About 60 percent of the people who present with Axis 1 or Axis 2 diagnoses have co-occurring disorders.

Comprehensive Psychiatric Emergency Program (CPEP): This program provides onsite emergency psychiatric evaluations for people 18 years of age and older who are in crisis. Mobile crisis services are also available for individuals of all ages in the District. Psychiatric observation beds are also available as a treatment option at the CPEP building at DC General Hospital. Funding required for the evaluation and treatment of individuals with co-occurring substance abuse and mental health disorders are considered substance abuse-related.

Community Contract Providers: Assertive Community Treatment and other services provided to people with co-occurring substance abuse and mental health disorders are considered to be substance abuse-related.

Public Core Services Agency: Assertive Community Treatment and other services provided to people with co-occurring substance abuse and mental health disorders are considered to be substance abuse-related.

Integrated School-Based Mental Health Budget: Services provided to children and youth with co-occurring substance abuse and mental health disorders are considered to be substance abuse-related.

Homeless Support Services and DC Pathways Grant: Services provided to people with co-occurring substance abuse and mental health disorders are considered to be substance abuse-related.

METROPOLITAN POLICE DEPARTMENT (MPD)

(dollars in thousands)

Agency/Program	FY 2003	FY 2004
Regional Field Ops.	$105,777.4	$113,290.6
Narcotics Investigations	5,305.7	4,162.2
District and Spec. Invest.	32,695.1	28,713.5
Call Taking and Dispatching	12,585.7	16,041.2
Youth and Prev. Services	300.2	300.0
Youth Violence Prev.	105.0	---
Youth Problem Solving Partnership	367.0	275.0
Community Partnership Project	397.9	300.0
Total	$157,534.1	$163,082.5
Funding Source		
DC Budget	$150,617.4	$153,742.0
Federal	4,247.5	3,090.8
Other	2,669.1	6,249.6
Total	$157,534.1	$163,082.5
Function		
Enforcement	$156,364.0	$162,207.5
Prevention	1,170.1	875.0
Total	$157,534.1	$163,082.5

Population Served

Regional Field Operations: Regional Field Operations serves the residents of the District of Columbia through its law enforcement activities.

Narcotics Investigations: Narcotics Investigations is a special unit within the Metropolitan Police Department specifically established to work narcotics cases.

District and Special Investigations: District and Special Investigations is a unit within the Metropolitan Police Department

with the expertise to conduct investigations into a broad range of criminal activities within the District of Columbia.

Call Taking and Dispatching: Call Taking and Dispatching serves as the interface between the residents and visitors to the District of Columbia and the police.

Youth and Prevention Services: Youth and Prevention Services works with youths in the District of Columbia.

Youth Violence Prevention: Youth Violence Prevention works with youths in the District who are between 16 and 26 years old, specifically focusing its efforts toward preventing violence.

Youth Problem Solving Partnership: The Youth Problem Solving Partnership works with youths in the District of Columbia who are between the ages of 12 and 18 years.

Community Partnership Project: The Community Partnership serves the residents of various District neighborhoods with significant drug crime and violence problems.

Substance Abuse-Related Services

Regional Field Operations: Regional Field Operations is responsible for enforcing laws in the District of Columbia, including those related to the distribution and use of illicit drugs. The Metropolitan Police Department lacks the ability to directly determine the number or substance abuse-related crimes. Instead, the MPD uses an assumption that the percentage of arrestees that tested positive for any drug as reported by the Bureau of Justice Statistics' ADAM program also represents a reasonable proxy measure for percentage of overall crime and crime-related workload that is substance abuse-related.

Narcotics Investigations: Narcotics Investigations works exclusively on the investigation of crimes related to the trafficking of illegal drugs in the District of Columbia. All of its activities are substance abuse-related.

District and Special Investigations: District and Special Investigations is responsible for conducting criminal investigations on a broad range of crimes in the District of Columbia. Among the crimes it investigates are those that involve the distribution of illicit drugs. The Metropolitan Police Department lacks the ability to directly determine the number or substance abuse-related crimes. Instead, the MPD uses an assumption that the percentage of arrestees that tested positive for any drug as reported by the Bureau of Justice Statistics' ADAM program also represents a reasonable proxy measure for percentage of overall crime and crime-related workload that is substance abuse-related.

Call Taking and Dispatching: The Metropolitan Police Department lacks the ability to directly determine the number or substance abuse-related crimes. Instead, the MPD uses an assumption that the percentage of arrestees that tested positive for any drug as reported by the Bureau of Justice Statistics' ADAM program also represents a reasonable proxy measure for percentage of overall crime and crime-related workload that is substance abuse-related.

Youth and Prevention Services: Youth and Prevention Services supports a number of activities directed toward youths in the District of Columbia. The Metropolitan Police Department lacks the ability to directly determine the number or substance abuse-related crimes. Instead, the MPD uses an assumption that the percentage of arrestees that tested positive for any drug as reported by the Bureau of Justice Statistics' ADAM program also represents a reasonable proxy measure for percentage of overall crime and crime-related workload that is substance abuse-related.

Youth Violence Prevention: Youth Violence Prevention supports activities directed toward reducing violence by youths in the District of Columbia. Those activities related to the prevention of youth violence from the use or distribution of illicit substances are considered substance abuse-related.

Youth Problem Solving Partnership: The Youth Problem Solving Partnership supports a number of activities directed toward youths in the District of Columbia. The activities related to improving the resiliency against drug use or drug-related criminal involvement of youths who participate in the program are considered substance abuse-related.

Community Partnership Project: Because these partnerships were established to assist residents in various District communities with significant drug crime and violence, all of the activities of the partnerships are considered to be substance abuse-related.

NEIGHBORHOOD SERVICES

(dollars in thousands)

Agency/Program	FY 2003	FY 2004
Neighborhood Services	---*	---*
Funding Source		
DC Budget	---*	---*
Function		
Prevention	---*	---*

* Note: Although Neighborhood Services has activities that are substance abuse-related, the nature of the activities makes it difficult to determine a specific expenditure level.

Population Served

Neighborhood Services Coordinators work with all residents in the District of Columbia.

Substance Abuse-Related Services

Neighborhood Services Coordinators work to assist residents of local communities in dealing with all of the problems they face, serving as a liaison to the residents for appropriate services in the District of Columbia. As part of their workload, coordinators assist residents in dealing with issues related to substance abuse. Coordinators in Wards 2, 4, 5, and 7 report being involved in activities that are substance abuse-related.

OFFICE OF CORPORATION COUNSEL (OCC)/CRIMINAL/JUVENILE

(dollars in thousands)

Agency/Program	FY 2003	FY 2004
OCC/Criminal/Juvenile	$2.5	$1.0
Funding Source		
DC Budget	$2.5	$1.0
Function		
Prevention	$2.0	$0.5
Treatment	0.5	0.5
Total	$2.5	$1.0

Population Served

The Office of Corporation Counsel (OCC)/Criminal/Juvenile serves lawyers, senior decision-makers, legislative advisors, and policy advisors and within DC government.

Substance Abuse-Related Services

The Legal Counsel Division reviews draft legislative bills and rulemakings, including those related to substance abuse. In addition, Investigations has a limited involvement in the substance abuse program by serving summonses/subpoenas in cases related to substance abuse. However, expenditure estimates for Investigations have not been developed because there is no tracking system that would allow it to know the underlying issue on which the subpoena/summons is based.

DEPARTMENT OF PARKS AND RECREATION

(dollars in thousands)

Agency/Program	FY 2003	FY 2004
Dept. of Parks and Rec.	$44.3	$41.0
Funding Source		
DC Budget	$44.3	$41.0
Function		
Prevention	$44.3	$41.0

Population Served

The Department of Parks and Recreation maintains public parks and develops and implements recreational activities for youths throughout the District of Columbia.

Substance Abuse-Related Services

The Department of Parks and Recreation has a staff of professionals that provides specialized intervention and social support services to at-risk youths in targeted communities. These outreach workers have a background in and specialized knowledge of youth gang prevention and other crime deterrence strategies. Outreach workers are deployed to communities marred by high rates of youth violence and unrest to provide mentoring and social support services to youth who are at risk for involvement in criminal activity. Moreover, outreach workers conduct community outreach to mobilize residents around the issues that contribute to youth violence, spearhead crime-watch activities, and serve as young people's liaison to schools, courts, employment opportunities, and many non-profit organizations that serve young people.

DISTRICT OF COLUMBIA PUBLIC SCHOOLS (DCPS)

(dollars in thousands)

Agency/Program	FY 2003	FY 2004
Student Intervention Services Branch	$1,221.0	---
Extra Duty Pay Allocation	117.3	117.3
Weighted Student Formula	3,405.2	3,405.2
HIV/AIDS Program	286.1	286.1
Oak Hill Academy	197.0	$197.0
Total	$5,226.6	$4,005.6
Funding Source		
DC Budget	$3,719.5	$3,719.5
Federal	1,507.1	286.1
Total	$5,226.6	$4,005.6
Function		
Prevention	$5,226.6	$4,005.6

Population Served

Student Intervention Services Branch: The Student Intervention Services Branch works with students in grades K-12 as well as teachers and staff. The program serves students in District of Columbia Public Schools (DCPS) and non-public schools, including charter schools and parochial schools. The program also involves the parents of students and works with multiple community partners.

Extra Duty Pay: The Extra Duty Pay allocation benefits students in DCPS grades K-12.

Weighted Student Formula: The Weighted Student Formula local school allocation benefits students in DCPS grades K-12.

HIV/AIDS Program: The HIV/AIDS program is for students in grades 6-12, which includes middle school, junior high school and high school students in the District. The program also supports teacher and staff training.

Oak Hill Academy: Oak Hill Academy serves adjudicated and committed juveniles from 13 to 21 years of age.

Substance Abuse-Related Services

Student Intervention Services Branch: The Student Intervention Services Branch supports prevention services funded by federal Title IV funding. Substance abuse prevention services include: Prevention/ Awareness Education for Students in grades K-12; youth development conferences; Youth Risk Behavior Survey Data Collection; Staff development training workshops and prevention-focused courses; Training Needs Assessment Survey of school staff members; Dissemination of resources and materials for staff and students including newsletters and pamphlets; Parent-Centered Support Programs; and Attendance intervention, student and family counseling support, and referral to supporting agencies.

Extra Duty Pay: The Extra Duty Pay allocation allows each school to provide compensation for local school coordinators in elementary schools, middle schools, junior high schools, and senior high schools for extra duty pay activities. The extra duty pay for substance abuse-related activities is shown.

Weighted Student Formula: The Health and Physical Education teachers assigned to K-12 schools teach substance abuse awareness and prevention as part of the DCPS Standards-Based Health and Physical Education Curriculum.

HIV/AIDS Program: The HIV/AIDS program provides training and services to

DCPS students in prevention. This program is funded by the Centers for Disease Control and Prevention (CDC) and is responsible for the coordination of data collection using the Youth Risk Behavior Survey.

Oak Hill Academy: Oak Hill Academy provides Substance Abuse Awareness, Conflict Resolution and Refusal Skills, Life Skills Program, and a prevention-focused Substance Abuse Curriculum (primarily through science, health, and physical education programs).

DISTRICT OF COLUMBIA SUPERIOR COURT

(dollars in thousands)

Agency/Program	FY 2003	FY 2004
Social Service Office	$2.0	$2.5
Drug Court Program	79.0	82.5
Total	$81.0	$85.0
Funding Source		
Federal	$81.0	$85.0
Function		
Prevention	$2.0	$2.5
Treatment	79.0	82.5
Total	$81.0	$85.0

Population Served

Social Service Office: The Social Service Office supports a mood altering chemical-free intervention group serving substance-abusing youths 14 to 18 years old.

Drug Court Program: The Drug Court Program serves youths 14 to 18 years old.

Substance Abuse-Related Services

Social Service Office: Youths are screened via the Substance Abuse Subtle Screening Inventory (SASSI) to determine if a youth has a substance abuse problem. For those admitted to the Mood Altering Chemical-Free Group, there is a nine-week educational curriculum. Each topic in the curriculum is discussed for an hour and a half.

Drug Court Program: Each individual participating in the Drug Court Program is assigned a probation officer and a certified substance abuse counselor. There is also a year-long program that has three phases for non-violent juvenile offenders who demonstrate substance dependency problems. The program includes the following services: individual and group counseling, cultural and educational events, family counseling, drug testing twice a week, random breathalyzer testing, and psychological evaluation.

DC Substance Abuse Expenditures -- Agency Tables

(dollars in thousands)

	Function	FY 2003 Local	FY 2003 Federal	FY 2003 Other	FY 2003 Total	FY 2004 Local	FY 2004 Federal	FY 2004 Other	FY 2004 Total
Children & Families Services Agency									
Office of Clinical Practice									
Case Management: Linkage/referral	Treatment	1,244.766	613.093	---	1,857.859	938.000	462.000	---	1,400.000
Total, Children & Families Services Agency		**1,244.766**	**613.093**	**---**	**1,857.859**	**938.000**	**462.000**	**---**	**1,400.000**
Funding not identified as Local/Fed/Other					**---**				**---**
Court Services & Offender Supervision Agency									
Detox, Residential, & Outpatient	Treatment	---	11,100.000	---	11,100.000	---	11,100.000	---	11,100.000
Total, Court Serv. & Offender Supervision Ag.		**---**	**11,100.000**	**---**	**11,100.000**	**---**	**11,100.000**	**---**	**11,100.000**
Funding not identified as Local/Fed/Other					**---**				**---**
Department of Corrections									
Prisoner Security	Corrections	35,000.000	---	---	35,000.000	35,000.000	---	---	35,000.000
Substance Abuse Support Services	Corrections	4,240.277	---	---	4,240.277	4,240.277	---	---	4,240.277
Sub. Abuse Treatment Readiness Programming	Treatment	302.100	---	---	302.100	302.100	---	---	302.100
Residential Substance Abuse Treatment Program	Treatment	---	334.870	---	334.870	---	334.870	---	334.870
Meth Maint., Alcohol Detox., Prev/Ed Services	Treatment	100.000	---	---	100.000	100.000	---	---	100.000
Co-Occuring Disorders - S.A. & M.H. Services	Treatment	1,635.480	---	---	1,635.480	1,635.480	---	---	1,635.480
Substance Abuse Treatment Services at CTF	Treatment	1,368.247	---	---	1,368.247	1,368.247	---	---	1,368.247
Total, Department of Corrections		**42,646.104**	**334.870**	**---**	**42,980.974**	**42,646.104**	**334.870**	**---**	**42,980.974**
Funding not identified as Local/Fed/Other					**---**				**---**
Deparment of Health									
APRA									
Family Treatment Court	Treatment	1,163.371	2,262.286	---	3,425.657	388.000	1,598.270	---	1,986.270
Treatment - Prevention - Referrals									
Latino Continuum	Treatment	146.000	---	---	146.000	220.000	---	---	220.000
HIV/AIDS	Treatment	---	323.333	---	323.333	---	323.333	---	323.333
Asian/Pacific Islander	Treatment	---	100.000	---	100.000	---	100.000	---	100.000
Senior Services	Treatment	---	55.330	---	55.330	---	58.097	---	58.097
Office of Prevention & Youth									
Youth Treatment Continuum	Treatment	2,000.000	1,118.000	---	3,118.000	2,000.000	401.000	---	2,401.000
DC Youth State Incentive Grant	Prevention	---	2,197.105	---	2,197.105				---
Prison 28 Day Treatment Readiness Program	Treatment	---	---	302.100	302.100				---
Detoxification Programs									
7-10 Day Detox for Adults over Age 18	Treatment	3,244.029	615.427	---	3,859.456	3,406.228	646.198	---	4,052.426
Detox for Youth Aged 12 - 17 years	Treatment	505.150	---	---	505.150	505.150	---	---	505.150
Methadone Maintenance (18 and over)	Treatment	5,216.439	---	---	5,216.439	5,477.261	---	---	5,477.261
AMAC - Adult Abstinence Program	Treatment	1,246.324	---	---	1,246.324	1,308.640	---	---	1,308.640
Rap, Inc. - Residential Program	Treatment	2,626.158	---	---	2,626.158	2,626.158	---	---	2,626.158
Aftercare - Continuing Ed. For APRA programs	Prevention	621.212	---	---	621.212	652.273	---	---	652.273
Central Registry Division	Treatment	1,572.297	---	---	1,572.297	1,650.912	---	---	1,650.912
APRA Certification Unit									
Controlled Substances Registrations	Treatment	---	---	---	30.000 *	---	---	---	30.000 *
Tx Fac. Inspect., Monitoring and Cert.	Treatment	---	---	---	916.000 *	---	---	---	916.000 *
APRA Administrative Expenses	Treatment	5,824.808	4,012.208	427.090	10,264.106	4,588.378	7,168.102	234.000	11,990.480

DC Substance Abuse Expenditures -- Agency Tables

(dollars in thousands)

	Function	FY 2003 Local	FY 2003 Federal	FY 2003 Other	FY 2003 Total	FY 2004 Local	FY 2004 Federal	FY 2004 Other	FY 2004 Total
HIV/AIDS Administration									
Prevention Education and Referral (IDU)	Prevention	---	---	156.000	156.000	---	---	156.000	156.000
Outpatient HIV/AIDS dually diagnosed s.a.	Treatment	---	---	---	1,034.342 *	---	---	---	1,034.342 *
Residential HIV/AIDS dually diagnosed s.a.	Treatment	---	---	---	300.000 *	---	---	---	300.000 *
Maternal & Family Health Administration									
Teen Mothers Take Charge	Prevention	---	127.000	---	127.000	---	---	---	---
Healty Start and Health line	Treatment	---	---	---	---	---	---	---	---
Medical Affairs/Communicable and Chronic Disease									
TB Administration									
New Patient Evaluation	Treatment	20.000	40.000	---	60.000	18.400	38.600	---	57.000
Home Visit, Directly Observed Therapy	Treatment	357.000	---	---	357.000	---	328.440	---	328.440
Follow-Up / Education	Prevention	11.444	23.236	---	34.680	10.529	21.377	---	31.906
Patient Education Regarding TB	Prevention	---	3.400	---	3.400	---	3.128	---	3.128
STD Examination, Diagnosis, & Treatment	Treatment	800.000	1,500.000	---	2,300.000	---	1,500.000	---	1,500.000
UDC Student Clinic									
Screening Questionnaire	Treatment	---	---	---	18.000 *	---	---	---	---
Smoking Cessation	Treatment	---	---	---	4.000 *	---	---	---	---
Total, Department of Health		**25,354.232**	**12,377.325**	**885.190**	**40,919.089**	**22,851.929**	**12,186.545**	**390.000**	**37,708.816**
Funding not identified as Local/Fed/Other					***2,302.342***				***2,280.342***
DC Housing Authority									
Fight Back Evictions & Property Damage Repair	Prevention	---	850.000	---	850.000	---	---	---	---
Total, DC Housing Authority		**---**	**850.000**	**---**	**850.000**	**---**	**---**	**---**	**---**
Funding not identified as Local/Fed/Other					**---**				**---**
Department of Human Services									
Income Maintenance Administration									
Substance Abuse Treatment/Prevention	Treatment	998.720	---	---	998.720	998.720	---	---	998.720
Office of Early Childhood Development									
Day Care	Prevention	---	53.424	---	53.424	---	53.424	---	53.424
Office of General Counsel									
Legislative Review	Prevention	1.500	---	---	1.500	.500	---	---	.500
Legal Sufficiency Review									
Comp. Youth S.A. Treatment System	Treatment	.500	---	---	.500	.500	---	---	.500
Drug and Alcohol test/report for YSA empl.	Prevention	.500	---	---	.500	.500	---	---	.500
Rehabilitation Services Administration									
Vocational Rehabilitation Case Management	Prevention	80.000	316.000	---	396.000	88.000	347.600	---	435.600
Youth Services Administration									
Outpatient S.A. Treatment - Relapse	Treatment	692.778	---	---	692.778	692.778	---	---	692.778
Oak Hill Youth Center and Inpatient Services	Treatment	917.744	121.000	---	1,038.744	917.744	121.000	---	1,038.744
Substance Abuse Related Programs	Prevention	2,494.840	---	---	2,494.840	2,556.168	---	---	2,556.168
Family Services Administration									
Case Management & Relerral Services									
Homess Individuals	Treatment	106.756	---	---	106.756	106.756	---	---	106.756
Case Mgmt and Ref'ls for Homeless Fam.	Treatment	---	7.569	---	7.569	---	7.569	---	7.569
Total, Dept. of Human Services		**5,293.338**	**497.993**	**---**	**5,791.331**	**5,361.666**	**529.593**	**---**	**5,891.259**
Funding not identified as Local/Fed/Other					**---**				**---**

DC Substance Abuse Expenditures -- Agency Tables

(dollars in thousands)

	Function	FY 2003 Local	FY 2003 Federal	FY 2003 Other	FY 2003 Total	FY 2004 Local	FY 2004 Federal	FY 2004 Other	FY 2004 Total
Department of Mental Health									
St. Elizabeth's Hospital									
Acute Care	Treatment	31,798.143	16,600.857	---	48,399.000	31,798.143	16,600.857	---	48,399.000
Community Contract Providers	Treatment	12,148.998	6,342.627	---	18,491.625	12,148.998	6,342.627	---	18,491.625
Public Core Services Agency (ACT)	Treatment	12,159.235	6,347.972	---	18,507.207	12,159.235	6,982.769	---	19,142.004
Integrated School-based M.H. Budget	Prevention	1,074.689	---	---	1,074.689	1,182.168	---	---	1,182.168
Homeless Support Services & DC Pathways	Treatment	2,434.205	---	770.000	3,204.205	2,434.205	539.000	---	2,973.205
Total, Department of Mental Health		**59,615.270**	**29,291.456**	**770.000**	**89,676.726**	**59,722.749**	**30,465.253**	**---**	**90,188.002**
Funding not identified as Local/Fed/Other					**---**				**---**
Metropolitan Police Department									
Youth and Prevention Services	Prevention	---	300.183	---	300.183	---	300.000	---	300.000
Youth Violence Prevention	Prevention	---	105.000	---	105.000	---	---	---	---
Youth Problem Solving Partnership	Prevention	---	367.000	---	367.000	---	275.000	---	275.000
Capitol Communities Partnerships	Prevention	---	397.909	---	397.909	---	300.000	---	300.000
Regional Field Operations	Enforcement	105,004.991	772.453	---	105,777.444	112,444.326	846.300	---	113,290.626
Narcotics Investigations	Enforcement	5,305.746	---	---	5,305.746	4,014.547	147.608	---	4,162.155
District and Special Investigations	Enforcement	30,445.560	2,249.516	---	32,695.076	27,491.616	1,221.929	---	28,713.545
Call-Taking and Dispatching	Enforcement	9,861.116	55.478	2,669.100	12,585.694	9,791.554	---	6,249.600	16,041.154
Total, Metropolitan Police Department		**150,617.413**	**4,247.539**	**2,669.100**	**157,534.052**	**153,742.043**	**3,090.837**	**6,249.600**	**163,082.480**
Funding not identified as Local/Fed/Other					**---**				**---**
Neighborhood Services									
Ward 4 Activities	Prevention	---	---	---	---	---	---	---	---
Ward 5 Activities	Prevention	---	---	---	---	---	---	---	---
Ward 7 Activities	Prevention	---	---	---	---	---	---	---	---
Ward 2 Activities	Prevention	---	---	---	---	---	---	---	---
Total, Neighborhood Services		**---**	**---**	**---**	**---**	**---**	**---**	**---**	**---**
Funding not identified as Local/Fed/Other					**---**				**---**
OCC / Criminal / Juvenile									
Review legslation & conduct analysis on DHS employee drug and alcohol testing	Prevention	1.500	---	---	1.500	---	---	---	---
Review legal sufficiency, MOU for Comp. S.A. Treat. System between DOH and DHS	Treatment	.500	---	---	.500	.500	---	---	.500
Reviewed legal sufficiency, MOU between DOC and DHS to est. terms for DOC to conduct drug and alcohol testing	Prevention	.500	---	---	.500	.500	---	---	.500
Total, OCC / Criminal / Justice		**2.500**	**---**	**---**	**2.500**	**1.000**	**---**	**---**	**1.000**
Funding not identified as Local/Fed/Other					**---**				**---**
Department of Parks & Recreation									
Division of Youth	Prevention	44.300	---	---	44.300	41.000	---	---	41.000
Total, Dept. of Parks and Recreation		**44.300**	**---**	**---**	**44.300**	**41.000**	**---**	**---**	**41.000**
Funding not identified as Local/Fed/Other					**---**				**---**

DC Substance Abuse Expenditures -- Agency Tables

(dollars in thousands)

	Function	FY 2003 Local	FY 2003 Federal	FY 2003 Other	FY 2003 Total	FY 2004 Local	FY 2004 Federal	FY 2004 Other	FY 2004 Total
DC Public Schools									
Student Intervention Services Branch	Prevention	---	1,221.000	---	1,221.000	---	---	---	---
Extra Duty Pay Allocation	Prevention	117.306	---	---	117.306	117.306	---	---	117.306
Weighted Student Formula Local School Allocation	Prevention	3,405.185	---	---	3,405.185	3,405.185	---	---	3,405.185
HIV/AIDS Program	Prevention	---	286.101	---	286.101	---	286.101	---	286.101
Oak Hill Academy	Prevention	197.000	---	---	197.000	197.000	---	---	197.000
Total, DC Public Schools		**3,719.491**	**1,507.101**	**---**	**5,226.592**	**3,719.491**	**286.101**	**---**	**4,005.592**
Funding not identified as Local/Fed/Other					**---**				**---**
DC Superior Court									
Social Service Office	Prevention	---	2.000	---	2.000	---	2.500	---	2.500
Drug Court Program	Treatment	---	79.000	---	79.000	---	82.500	---	82.500
Total, DC Superior Court		**---**	**81.000**	**---**	**81.000**	**---**	**85.000**	**---**	**85.000**
Funding not identified as Local/Fed/Other					**---**				**---**
Total, DC Substance Abuse Budget		**288,537.414**	**60,900.377**	**4,324.290**	**356,064.423**	**289,023.982**	**58,540.199**	**6,639.600**	**356,484.123**
Funding not identified as Local/Fed/Other					***2,302.342***				***2,280.342***

* The total includes expenditures for which the source of funding was not identified.

Appendix C

CONSULTATION WITH NON-GOVERNMENTAL ORGANIZATIONS

Views of the following organizations were considered during the formulation of the Strategy:

Advocates for Recovery through Medicine

Bread for the City

Catholic Charities

'Cause Children Count Coalition, Inc.

Community Partnership for Prevention of the Homeless

Consortium for Youth Services, Inc.

Covenant House, Washington

Demeter NW

Healthcare Services Development Corporation

Hillcrest Children's Center

Hospital for Sick Children

Howard University

Inner Thoughts, Inc.

Institute for Behavioral Change and Research

Lambda Center and Psychiatric Hospital

Marshall Heights Community Development Organization

Max Robinson Center

Metropolitan Washington Council of Governments

National Hispanic and Latino Committee on Alcohol and Tobacco

Neighbor's Consejo

Parkland Community Center

Partners in Drug Abuse Rehabilitation and Counseling

Providence Hospital

Psychiatric Institute of Washington

Riverside Hospital

RAP, Inc.

Recovery Community Association

Recovery Works

Salvation Army/Harbor Lights

Sasha Bruce Youthwork

Second Genesis, Inc.

Sociometrics, Inc.

St. Elizabeth's Hospital

Step Foundation

Time Dollar Institute

United Planning Organization

U.S. Department of Health and Human Services

Washington Behavioral Health Center

Whitman Walker